MEMBERSHIP ISSUE

JOURNAL

of the

NATIONAL ASSOCIATION *of* CHIROPODISTS

The Official Publication of the Profession

Fiftieth Anniversary Edition

Table of Contents Page A2

VOLUME 47, NUMBER 4 APRIL, 1957

a notable adjunct
to your professional skill

DESITIN®
OINTMENT

proven in extensive studies[1] and in over a quarter century of everyday use in chiropody to effectively . . .

SCALING DERMATITIS

relieve pain and itching, soothe, lubricate, soften, stimulate healthy granulation and accelerate healing in . . .

- **heloma and tyloma**
- **dermatitis**
- **inflamed nail grooves**
- **ulcers**
- **wounds**
- **sore joints**
- **scaling**
- **after nail removal**

PLANTAR HELOMA

DESITIN OINTMENT combines high grade Norwegian cod liver oil (with its unsaturated fatty acids and high potency vitamins A and D in proper ratio for maximum efficacy), zinc oxide, talcum, petrolatum and lanolin. Tubes of 1 oz., 2 oz., 4 oz., and 1 lb. jars.

DESITIN POWDER, scientifically balanced medicinal powder, is saturated with high grade Norwegian cod liver oil, and therefore it will not deprive the skin of its natural fat.

Samples and reprint on request.

DESITIN CHEMICAL COMPANY
Providence 4, R. I.

[1]Ignatoff, W. R., Journal National Assn. Chiropodists, December 1952

in fungus
infection...
avoid soap
irritation...
use
LOWILA
Your patient should stop using soap... its alkalinity creates an environment favoring the growth of fungi and bacteria. Lowila is soap free... does not contain free alkali or any other irritating soap components. Lowila cleanses tender or dermatitic skin without irritation, maintains the normal acid mantle of the skin and creates an environment favorable to therapy and normal healing ... degerms as it cleanses.
Westwood
PHARMACEUTICALS
Division of
Foster-Milburn Company
468 Dewitt Street,
Buffalo 13, New York
Write for samples
SOAP IRRITATION WASTES SOUND DERMATOLOGIC THERAPY ... RECOMMEND LOWILA

TABLE OF CONTENTS

	Page No.
A History of the Journal of the National Association of Chiropodists C. E. KRAUSZ, D.S.C., Ed.D.	169
A New Resilient Plastic for Orthodigital Prosthetics S. C. SIVITZ, D.S.C.	172
Hallux Valgus as Related to the First Metatarsal Length Pattern H. M. PLASTER, D.S.C.	176
Roentgenological Consideration of the Metatarsus—Part I B. D. SHERMAN, D.S.C., F.A.S.C.R.	180
Factors in the Use of the X-Ray Machine —Part I J. SETTLER, B.S., D.S.C.	183
Clinically Speaking Treatment of Heloma Durum with Cryotherapy R. L. MORGENSTERN, Pod.D.	186
Curetting Verrucae with Minimum Hemorrhage V. C. OVERCAST, D.S.C.	187
Surgical Removal of a Neurofibroma—A Case Report M. J. SOFFER, D.S.C.	188
President's Message	190
Editorial—Fifty Years of Information	192
Washington Report Congress Considers	193
Savings Through N.A.C. Insurance Plans	195
Techniques in Foot Surgery	196
The Podopediatric Clinic	198
Pharmaceutical Preparations for the Profession	200
Abstracts from the Chiropody Literature	203
Digests from the Literature	205
Affiliated State Societies	A6
Directory of Councils and Committees	A10
State Board Meetings	A12
Organization News	A17
Mood Elevators	A26
Convention Dates and Meeting Notices	A30
Deaths Reported	A31
Advertisers Index	A32

1957 Annual Meeting

Stimulating Scientific Sessions

House of Delegates

Specialty Society Meetings

Hall of Science

Science Theatre

NEW EXHIBITORS

Renew Old Friendships

Alumni Class Reunions

Ladies' Program

NATIONAL ASSOCIATION of CHIROPODISTS

DRAKE HOTEL

AUGUST 16, 17, 18, 19, 20 **CHICAGO, ILL.**

now! 2 strengths

new
PANTHO-F 0.2% cream

0.2% hydrocortisone with 2% pantothenylol

PANTHO-F 0.2% provides less costly treatment of extensive skin areas, or when therapy is long continued . . .

regular
PANTHO-F cream

1% hydrocortisone with 2% pantothenylol

PANTHO-F regular for the more severe and more stubborn dermatoses . .

. . . provide the dramatic anti-inflammatory action of hydrocortisone (free alcohol) plus the notable antipruritic, healing power of pantothenylol, in water-miscible, pleasant cream base

both PANTHO-F 0.2% . . . and PANTHO-F regular

	in
rapidly allays inflammation	pruritic lesions
relieves pain, itch, swelling	atopic dermatitis (allergic eczemas, etc.)
checks oozing and edema	contact dermatitis (poison ivy, oak, sumac, etc.)
promotes smooth granulation	dermatophytosis
accelerates healing	stasis dermatitis

PANTHO-F 0.2% in tubes of 15 Gm. and 2 oz.; 1 lb. jars.
PANTHO-F (regular) in 5 Gm. and 20 Gm. tubes.

Samples and literature on request.

u. s. vitamin corporation • PHARMACEUTICALS
(Arlington-Funk Laboratories, division) • 250 East 43rd Street, New York 17, N. Y.

THE JOURNAL

OF THE

NATIONAL ASSOCIATION OF CHIROPODISTS

3301 16th Street, N.W., Washington 10, D. C.

NOrth 7-4587

A. Rubin, D.S.C., Editor

F. R. Fielding, Business Manager

EXECUTIVE COUNCIL

Dr. Felton O. Gamble, *President*
1888 N. Country Club Road, Tucson, Ariz.

Dr. Jonas C. Morris, *President Elect*
108 W. Merchant Street, Audubon, N. J.

Dr. George E. Guenzler, *Vice President*
302 Smith Building, Freeport, Ill.

Dr. Marvin W. Shapiro, *Vice President*
1059 Spitzer Building, Toledo, Ohio

Dr. Ralph E. Fowler, *Retiring President*
16888 Greenfield, Detroit, Mich.

Dr. Morse K. Upshaw, Jr.
511-13 Lamar Life Bldg., Jackson, Miss.

Dr. Raymond K. Locke
134 Engle Street, Englewood, N. J.

Dr. James A. Conforti
767 Broadway, Bedford, Ohio

Dr. Alec C. Levin
1835 Eye St., N.W., Washington, D. C.

Dr. Harry I. Horowitz
30-96 Steinway St., Astoria, L. I., N. Y.

Dr. Charles R. Brantingham
311 Security Bldg., Long Beach, Calif.

A. Rubin, D.S.C., *Secretary*
Franklin R. Fielding, B.S., B.S.A., M.F., *Business Administrator*

All expressions of opinion and all other statements are published on the authority of the writer over whose signature they appear, and are not to be regarded as expressing the views of the National Association of Chiropodists, unless such statements or opinions have been adopted by the Association.

Deadline for *Journal* copy is the 10th of the month before publication (example: copy for June issue should be in our hands by May 10th.) The *Journal* is usually mailed between the 10th and 15th of the month noted on the issue (the June issue is mailed between the 10th and 15th of June).

Manuscripts must be typewritten, double spaced, and an original copy must be submitted. References should give name and initials of author, volume, page, month and year of publication in the case of periodicals, and publisher and place and year of publication in the case of books. Illustrations must be clear photographs. Glossy prints are preferred. Drawings must be made in black ink on heavy paper or cardboard. Any illustrations should bear the author's name and be numbered in the order in which they are referred to in the text. Illustrations must not be pasted on the manuscript. Legends should be placed on a separate sheet. Tables are not illustrations and should be numbered separately.

Articles are accepted with the understanding that they have not been published previously and that they are submitted solely to *The Journal*. Orders for reprints may be placed at the time manuscripts are submitted.

Communications regarding manuscripts, news items, and editorial matters should be addressed to the Editor, regarding advertising and business matters to the Business Manager. Advertising and editorial copy must conform to the official standards established by the Association.

Subscription is included in the annual membership dues of the National Association of Chiropodists. The subscription rate for non-members is $10.00 a year in advance. Single copies $1.00 each. Remittance should be made payable to the National Association of Chiropodists.

Notice of change of address should be received six weeks before the change is to become effective. Old and new address must be given.

The *Journal of the National Association of Chiropodists* is published monthly and copyrighted in 1957, by the National Association of Chiropodists.

Entered as second class matter at the P. O. at Boston, Mass., March 27, 1934, under the act of March 3, 1879. Publication office, 375 Broadway, Boston, and Editorial Executive offices 3301 16th St., N.W., Washington 10, D. C.

As a result of years of experience in the manufacture of X-ray equipment, the Ritter Chiropody X-ray Unit helps you to quickly obtain sharp, clear radiographs with ease. The Ritter Chiropody X-ray combined with the Ritter-Gamble Ortho-X-Poser permits the taking of radiographs in the weight-bearing position from varying angles, without changing the patient's position. The X-ray Unit is completely safe electrically, mechanically and radiographically.

Your professional skill can be utilized to the fullest extent with a Ritter Chiropody X-ray in your office. Visit your Ritter dealer and see the advantages of the Ritter Chiropody X-ray.

Or, Write The Ritter Company, Inc.
4028 Ritter Park, Rochester 3, New York

Ritter Company Inc.

RITTER PARK • ROCHESTER 3, N. Y.

AFFILIATED STATE SOCIETIES

Showing Society, President and Secretary

Alabama Association of Chiropodists	Dr. W. J. AuCoin, 806 Van Antwerp Bldg., Mobile, Ala. Dr. Elizabeth P. Sealy, 34 S. Perry St., Montgomery, Ala.
Arizona Chiropody Association	Dr. Howard Seyfert, Jr., 757 E. McDowell Rd., Phoenix, Ariz. Dr. Irwin D. Shapiro, 2814 N. 7th Ave., Phoenix, Ariz.
Arkansas Association of Chiropodists	Dr. John H. Gordon, 420 Fifth St., Texarkana, Ark. Dr. Walter C. Gigerich, Arkansas Nat'l Bank Bldg., Hot Springs, Ark.
California Association of Chiropodists, Inc.	Dr. Robert Shor, 4480 Crenshaw Blvd., Los Angeles, Calif. Mr. E. A. Devereux (Ex. Sec.), 1101 Vallejo Way, Sacramento, Calif.
Colorado Association of Chiropodists	Dr. Stanley C. Rheaume, 311 Bon Durant Bldg., Pueblo, Colo. Mrs. L. I. Lorett (Ex. Sec.), 4871 S. Penn, Englewood, Colo.
Connecticut Chiropody Society Inc.	Dr. Jerome Brand, 152 Temple St., New Haven, Conn. Dr. Margaret L. Halloran, 75 Pratt St., Hartford, Conn.
Delaware, Chiropody Society of	Dr. Martin Hirsch, North American Bldg., Wilmington, Del. Dr. Harold W. Orr, 2210 Baynard Blvd., Wilmington, Del.
District of Columbia Podiatry Society	Dr. Charles W. Shuffle, 1801 K St., N. W., Washington, D. C. Dr. Morris L. Selby, 419 Colorado Bldg., Washington, D. C.
Florida, Chiropody Association of	Dr. Allan S. Horn, 414-16 Empire Bldg., St. Petersburg, Fla. Dr. Joy E. Adams, 401 Fla. Natl. Bank Bldg., St. Petersburg, Fla.
Georgia Association of Chiropodists	Dr. Morton Wittenberg, 1126 Green St., Augusta, Ga. Dr. Ernest Godwin, 1101 Williams St., Valdosta, Ga.
Idaho Association of Chiropodists	Dr. J. E. Franden, 719 Main St., Boise, Idaho Dr. M. D. Harris, 341 W. Clark, Pocatello, Idaho
Illinois Chiropody Society	Dr. Philip R. Brachman, 25 E. Washington St., Chicago, Ill. Dr Max L. Golde, 2104 Broadway, Rockford, Ill.
Indiana State Podiatrists Association	Dr. Clarence W. Grinstead, 716 Lafayette Bldg., Lafayette, Ind. Dr. A. J. Deeley, 413 Gettle Bldg., Fort Wayne, Ind.
Iowa State Chiropody Association	Dr. R. R. Carnes, Granby Bldg., Cedar Rapids, Iowa Grace C. Alber (Ex. Sec.), 638 37th St., Des Moines, Iowa
Kansas State Chiropody Association	Dr. Don M. Miller, 302 Wolcott Bldg., Hutchinson, Kansas Dr. R. L. Wright, 4712-A East Central, Wichita, Kansas
Kentucky Association of Chiropodists	Dr. Stanley Stivers, 1409 Broadway, Paducah, Ky. Dr. Chester A. Nava, 728 Starks Bldg., Louisville, Ky.
Louisiana State Chiropodists' Association	Dr. Henry G. Llorens, 2210 Line Ave., Shreveport, La. Dr. Harry Wax, 1018 Maison Blanch Bldg., New Orleans, La.
Maine, Chiropody Society of	Dr. Henry P. Landers, Garnsey Bldg., 243 Main St., Sanford, Maine Dr. Gerald Rosen, 132 Main St., Biddeford, Maine
Maryland Chiropody Association	Dr. Irvin N. Samuels, 800 Old Georgetown Rd., Bethesda, Md. Dr. M. D. Fielding, 7942 Wisconsin Ave., Bethesda, Md.
Massachusetts Chiropody Association	Dr. Frank N. Maconi, 6 Beacon St., Boston, Mass. Dr. Sidney G. Holmes, 206 Huntington Ave., Boston, Mass.
Michigan Chiropody Association	Dr. B. C. Stein, 9621 Jos. Campau, Hamtramck, Mich. Mr. J. R. Dawson (Ex. Sec.), 19 N. Washington, Ypsilanti, Mich.
Minnesota Association of Chiropodists	Dr. Edward L. Tarrara, Mayo Clinic, Rochester, Minn. Dr. Robert E. Adams, 213 First Nat. Bank Bldg., Rochester, Minn.
Mississippi Society of Chiropodists, Inc.	Dr. Sally E. Lynch, 202 Gulf National Bank Bldg., Gulfport, Miss. Dr. M. K. Upshaw, Jr., 511-13 Lamar Life Bldg., Jackson, Miss.
Missouri Association of Chiropodists	Dr. Erwin Hindes, 812 Olive St., St. Louis, Mo. Dr. C. B Footlick, 520-22 12th & Walnut Bldg., Kansas City, Mo.
Montana Association of Chiropodists	Dr. D. C. Scott, 315 Barber-Lydiard Bldg., Great Falls, Mont. Dr. L. M. Jennings, Rm. 1, Lovelace Bldg., Bozeman, Mont.
Nebraska Association of Chiropodists	Dr. Norman F. Soboda, 239 W. 6th, Fremont, Nebr. Dr. L. G. Lefler, 239 W. 6th, Fremont, Nebr.
Nevada Association of Chiropodists	Dr. B. E. Edwards, Medico Dental Bldg., Reno, Nevada Dr. William A. Edwards, 150 Chestnut St., Reno, Nevada
New Hampshire Chiropody Association	Dr. Harvey V. Harrison, 440 Central Ave., Dover, N. H. Dr. Tomy M. Levingston, 39 Pleasant St., Portsmouth, N. H.
New Jersey Chiropodists' Society	Dr. Samuel C. Goldstein, 790 Broad St., Newark, N. J. Dr. Jack Horwitz, 463 High St., Burlington, N. J.
New Mexico Association of Chiropodists	Dr. Morris Haas, 1301 Central Ave., N. E., Albuquerque, N. Mex. Dr. I. Michael Gross, 205-A Truman, N. E., Albuquerque, N. Mex.
New York, The Podiatry Society of the State of	Dr. Irving L. Marks, 207 Merchants Bank Bldg., Elmira, N. Y. Mr. G. Hollander (Ex. Sec.), 353 W. 57th St., New York, N. Y.
North Carolina Chiropodists' Association	Dr. Basil M. Tucker, Chandler Bldg., Leaksville, N. C. Dr. D. J. Cameron, 401-402 Murchison Bldg., Wilmington, N. C.
North Dakota Association of Chiropodists	Dr. J. E. O'Brien, Box 872, Bismarck, No. Dak. Dr. E. B. Snuff, 611 1st Ave, No., Fargo, No. Dak.

Desenex®

POWDER

"AN OUNCE-AND-A-HALF OF PREVENTION"

in superficial
fungous infections
of the feet, **especially**

DERMATOMYCOSIS PEDIS
(athlete's foot)

Reducing by more than 85% the incidence of infection in a controlled study of 5600 servicemen, Desenex Powder dramatically demonstrated its prophylactic efficacy.

As continuous therapy reportedly gives best results, the following simple regimen is suggested:

NIGHT **DESENEX OINTMENT** applied liberally to infected and surrounding areas each night before retiring.

DAY **DESENEX POWDER** applied each morning by dusting freely on feet (gently rubbing in) and in shoes and socks.

Available at all pharmacies as:

POWDER Zincundecate:
1½ oz. shakers & 1 lb. cans

OINTMENT Zincundecate:
1 oz. tubes & 1 lb. jars

SOLUTION Undecylenic Acid:
2 oz. & pt. bottles

Cures the average moderate to severe case in from one to three weeks.

Write for SAMPLES and literature

PD-58

Malthie
MALTBIE LABORATORIES DIVISION
WALLACE & TIERNAN INC.
25 MAIN ST., BELLEVILLE 9, NEW JERSEY, U.S.A.

Ohio Chiropodists Association	Dr. Charles E. Greiner, 887 So. High St., Columbus, Ohio Mr. J. E. Farmer (Ex. Sec.), 30 E. Broad St., Columbus, Ohio
Oklahoma Chiropody Association	Dr. Harry L. Bonnell, 302 Community Bldg., Ponca City, Okla. Dr. H. R. Johnson, 401 N. Beard St., Shawnee, Okla.
Oregon State Association of Chiropodists	Dr. W. R. Schiess, 209 E. Third St., The Dalles, Oregon Dr. George McCauley, 1700 N. E. 41st St., Portland, Oregon
Pennsylvania, Chiropody Society of	Dr. William F. Jeffery, 452 W. Market St., York, Pa. Dr. Arnold W. Newman, 5411 Chester Ave., Philadelphia, Pa.
Rhode Island Chiropodists' Society	Dr. A. Joseph O'Rourke, 176 Academy Ave., Providence, R. I. Dr. Samuel Kouffman, 290 Westminster St., Providence, R. I.
South Carolina Chiropody Association	Dr. Philip Cogen, 4 W. Court St., Greenville, So. Car. Dr. H. A. McAninch, 221 East Main St., Spartanburg, So. Car.
South Dakota Association of Chiropodists	Dr. M. D. Scofield, 115 N. Maine Ave., Sioux Falls, So. Dak. Dr. Robert E. Lee, 1900 So. Minnesota Ave., Sioux Falls, So. Dakota
Tennessee Chiropody Association	Dr. N. David Riddle, 353 E. Main St., Johnson City, Tenn. Dr. Stephen A. Lamm, 3355 Poplar Ave., Memphis, Tenn.
Texas, Chiropody Society of	Dr. Joseph R. Ordile, 111 Professional Bldg., Ft. Worth, Texas Dr. B. M. Sanders, 302 Peoples National Bank Bldg., Tyler, Texas
Utah State Association of Chiropodists	Dr. L. C. Larsen, 701 Medical Arts Bldg., Salt Lake City, Utah Dr. Paul W. Smith, 316 Darling Bldg., Salt Lake City, Utah
Vermont Chiropody Association	Dr. R. M. Coburn, South Main St., White River Junction, Vt. Dr. Regis P. Nolin, 14 Clarke St., Burlington, Vt.
Virginia Association of Chiropodists	Dr. Samuel Kaufman, Chief Tassle Bldg., Martinsville, Va. Dr. Herman Chapel, 644 New Monroe Bldg., Norfolk, Va.
Washington State Chiropody Association	Dr. F. L. Peck, 308 Security Bldg., Olympia, Wash. Dr. E. P. Erickson, 706-8 Mohawk Bldg., Spokane, Wash.
West Virginia, Chiropody Society of	Dr. G. M. Arnold, 216½ Seventh Ave., So. Charleston, W. Va. Dr. Malcolm P. Iams, 428 Market St., Parkersburg, W. Va.
Wisconsin Society of Chiropodists	Dr. Ralph R. Wichgers, 2218 N. Third St., Milwaukee, Wis. Dr. E. M. Hatfield, 270 W. Broadway, Waukesha, Wis.
Wyoming Association of Chiropodists	Dr. John B. Holthouse, Worland Foot Clinic, Worland, Wyoming Dr. Duane NeuSchultz, 136 W. 22nd Ave., Torrington, Wyoming

Affiliated Organizations

N.A.C. Women's Auxiliary—Mrs. Miriam Shor, 4480 Crenshaw Blvd., Los Angeles, Calif.
Military Association of Chiropodists—Dr. Martin Mussman, Veterans Administration Hospital, Montrose, N. Y.
American College of Foot Surgeons—Dr. J. M. Kohl, 3959 No. Lincoln Ave., Chicago, Ill.
American Society of Chiropodical Roentgenology—Dr. D. C. Rasmussen, City National Bank Bldg., Danbury, Conn.
Chiropody Bibliographical Research Society—Dr. S. E. Reed, 425 Kresge Bldg., Des Moines, Iowa
American College of Foot Orthopedists—Dr. Herman R. Siegler, 39 Flamingo Rd., Levittown, L. I., N. Y.
American Association of Hospital Chiropodists—Dr. Ronald E. Tanner, 304 Bankers Trust Bldg., Indianapolis, Ind.
National Association of Chiropody Students—D. S. Weidner, 1420 Old Wyoming Rd., Reading, Pa.

Non-Affiliated

The Federation of Chiropody Boards—Dr. L. A. Hansen, 800 Professional Bldg., Kansas City, Mo.
American Association of Colleges of Chiropody—Dr. Charles E. Krausz, 926 W. Lehigh Ave., Philadelphia, Pa.

AT LAST — A.D.M.*

A new self-molding, self-balancing forefoot inlay in combination with a completely prebalanced rear foot appliance (flexible or semi-rigid). Overwhelming acceptance by all its present users. Offered to the profession exclusively by the developers of the Impression Inlay.[1]
Send pedigraph, chart or cast and shoe size. Available in full insole length.

* AUTO DYNAMIC MOLD

[1] A New Self-Conforming, Self-Molding Inlay (Impression Insole), *J.N.A.C., Vol. 46, No. 5, May 1956, p. 325.*

hirsch laboratories
ORTHOPEDIC FOOT SPECIALTIES
5814 WEST THIRD STREET • LOS ANGELES 36, CALIFORNIA

PREPARATIONS FOR THE CHIROPODIST

Soapless Sudsing ***Antibacterial Detergent***

pHisoHex®

Cumulative bacteriostatic action in

Infections
(prophylactic-therapeutic)

Bromidrosis

Vascular disease of the extremities

pHisoderm® *(OILY TYPE)*

for dry feet and legs

Dependable Antiseptic for Office Use

ZEPHIRAN® CHLORIDE

(brand of benzalkonium chloride—refined)

Powerful

Economical

Versatile

Pioneer Local Anesthetic

NOVOCAIN®

(brand of procaine hydrochloride)

Quick onset

Dependable action

Excellent tolerance

WINTHROP LABORATORIES New York 18, N. Y., Windsor, Ont.

Write for informative illustrated booklet

DIRECTORY OF COUNCILS AND COMMITTEES

Council on Education
Dr. Stewart E. Reed, Chairman, 425 Kresge Bldg., Des Moines, Iowa

Council on Scientific Sections
Dr. Raymond K. Locke, Chairman, 134 Engle St., Englewood, N. J.

Committees:

Research—Dr. William F. Eads, Chairman, 1651 Garnet St., San Diego, Calif.

Technical Developments—Dr. Leroy C. Numbers, Chairman, 1327 N. Clark St., Chicago, Ill. Dr. William D. Readey, Co-Chairman, 1327 N. Clark St., Chicago, Ill.

Foot Surgery—Dr. Lester A. Walsh, Chairman, 709 N. Colorado Ave., Midland, Texas

Roentgenology—Dr. Ralph E. Sansone, Chairman, 1022 Farmington Ave., West Hartford, Conn.

Foot Orthopedics—Dr. Harvey Atkinson, Chairman, 462 Trapelo Rd., Belmont, Mass.

Hospital Chiropody—Dr. Ralph E. Fowler, Chairman, 16888 Greenfield, Detroit, Mich.

Pharmaceutical—Dr. Harry L. Hoffman, Chairman, 1098 National Press Bldg., Washington, D. C.

Shoes—Dr. Edward C. Meldman, Chairman, 161 W. Wisconsin Ave., Milwaukee, Wis.

Children's Foot Health—Dr. John T. Sharp, Chairman, 1424 Old York Rd., Abington, Pa.

Medical Chiropody (Dermatology)—Dr. Marvin D. Steinberg, Chairman, 630 Ft. Washington Ave., New York, N. Y.

Physical Medicine—

Mechanical Chiropody—Dr. Curry L. Meyer, Chairman, 347 E. Ferris St., Galesburg, Ill.

Operative Chiropody—Dr. C. Gordon Rowe, Chairman, 1033 Chestnut St., Philadelphia, Pa.

Council on Journalism
Dr. Ralph E. Fowler, Chairman, 16888 Greenfield, Detroit, Mich.

Committees:

Publications—Dr. Robert Shor, Chairman, 4480 Crenshaw Blvd., Los Angeles, Calif.

Nomenclature—Dr. Peter N. Varzos, Chairman, 25 E. Washington St., Chicago, Ill.

History and Library—Dr. Charles E. Krausz, Chairman, 926 W. Lehigh Ave., Philadelphia, Pa.

Council on External Affairs
Dr. James A. Conforti, Chairman, 767 Broadway, Bedford, Ohio

Committees:

Medical Relations—Dr. Earl L. Weibel, Chairman, 1921 N. W. 23rd St., Oklahoma City, Okla.

Nursing Relations—Dr. Lon H. Cooper, Chairman, 346-352 Ohio Bldg., Sidney, Ohio

Industrial Relations—Dr. George F. Holt, Chairman, 248 Charlotte St., Asheville, No. Car.

Commercial Relations—Dr. Albert R. Brown, Chairman, 7109 W. Vernor Highway, Detroit, Mich.

Council on Foot Health Information
Dr. Alec C. Levin, Chairman, 1835 Eye St., N. W., Suite 932, Washington, D. C.

Committees:

Public Education—Dr. H. L. Collins, Chairman, 318 E. State St., Columbus, Ohio

Public Relations—Dr. Burdette L. Anderson, Chairman, 21535 Lorain Rd., Fairview Park, Ohio

National Health Program—Dr. Arnold W. Newman, Chairman, 5411 Chester Ave., Philadelphia, Pa.

Speakers Bureau—Dr. Charles W. Shuffle, Chairman, 1801 K St., N. W., Washington, D. C.

Audio-Visual—Dr. Marvin W. Shapiro, Chairman, 1059 Spitzer Bldg., Toledo, Ohio

Council on Legislation
Dr. Morse K. Upshaw, Jr., Chairman, 511-513 Lamar Life Bldg., Jackson, Miss.

Committees:

Federal Affairs—Dr. Charles Turchin, Chairman, 818 18th St., N. W., Washington, D. C.

State Affairs—Dr. Joseph F. Healy, Chairman, 30 Court St., Westfield, Mass.

Military Affairs—Dr. Walter C. Gigerich, Chairman, Arkansas National Bank Bldg., Hot Springs, Ark.

Council on Membership
Dr. Harry I. Horowitz, Chairman, 30-96 Steinway St., Astoria, L. I., N. Y.

Committees:

State Society Membership—Dr. Wm. S. King, Chairman, Three Sisters Bldg., Memphis, Tenn.; Dr. Sam C. Abdoo, Co-Chairman, 2125 David Stott Bldg., Detroit, Mich.

Vocational Guidance—Dr. L. B. Thompson, Chairman, 705 Kenosha National Bank Bldg., Kenosha, Wis.; Dr. Milton Wolfson, Co-Chairman, 5 East 9th St., New York, N. Y.

Students Organization—Dr. M. D. Marr, Co-Chairman, 204 Paramount Bldg., Cedar Rapids, Iowa; Dr. Donald Altman, Co-Chairman, 767 Lexington Ave., Rm. 403, New York, N. Y.

Ethics—Dr. Ronald E. Fields, Chairman, 224 Bennie Dillon Bldg., Nashville, Tenn.

Chiropodical Assistants—Dr. John Forsythe, Chairman, 400 Washington Ave., Charleroi, Penna.

Council on Internal Affairs
Dr. Charles R. Brantingham, Chairman, 311 Security Bldg., Long Beach, Calif.

Committees:

Professional Economics—Dr. B. C. Egerter, Chairman, 909-11 Empire Bldg., Pittsburgh, Pa.

Museum—Dr. George Nelson, Chairman, 420 Kresge Bldg., Minneapolis, Minn.

Committee on NAC Insurance—Dr. Irving Pashin, 12 Catharine St., Poughkeepsie, N. Y.

Constitution and By-Laws Committee—Dr. J. V. Behar, Chairman, 61 Academy St., Newark, N. J.

Committee on Scientific Program—Dr. Jack Stern, Chairman, 25 E. Washington St., Chicago, Ill.

Now available !

for physiologic resolution of verrucae

and neurofibrous helomata ...

KERAMIN INJECTION

(Steinberg's Solution)

Keramin Injection may now be obtained through your pharmacist or supply house in one half cc. disposable glass ampuls packed in boxes of ten. If you prefer we will be glad to fill your order directly and invoice through the dealer you name. Literature is available on request.

References: Steinberg, J.N.A.C. *11*, 17 (1954). Steinberg, Surgery *39*, 642 (1956). Mullens, J.N.A.C. *46*, 772 (1956). Hoffman, J.N.A.C. *46*, 852 (1956).

Campbell Pharmaceutical Co.

79 Madison Avenue New York 16, N. Y.

STATE BOARD MEETINGS FOR EXAMINATION AND LICENSURE

Alabama
The Alabama Medical Board of Examiners. **Board Secretary:** Dr. Elizabeth P. Sealy, 34 South Perry Street, Montgomery, Ala.

Arizona
The Arizona State Board of Chiropody Examiners. **Board Secretary:** Dr. Julius Citron, 313 W. McDowell Road, Phoenix, Arizona.

California
The California Board of Medical Examiners. **Board Secretary:** Louis E. Jones, M.D., 1020 N Street, Room 530, Sacramento, Calif.

Delaware
The State Board of Chiropody Examiners of Delaware will hold its next examination the second week of July. **Board Secretary:** Dr. Bertram H. Blum, 112 So. State St., Dover, Dela.

District of Columbia
The Board of Podiatry Examiners of the District of Columbia. **Board Secretary:** Dr. Harry L. Hoffman, 1098 National Press Bldg., Washington, D. C.

Florida
The next board meeting of the Florida State Board of Chiropody Examiners will be held for examination on June 8-10, 1957, in Miami, Fla. **Board Secretary:** Dr. Heywood A. Dowling, 203 Greenleaf Bldg., Jacksonville, Fla.

Georgia
The Georgia State Board of Chiropody Examiners. **Board President:** Dr Charles W. Beasley, Jr., 1205 First National Bank Bldg., Atlanta, Ga.

Idaho
The next meeting of the Idaho State Board of Chiropody Examiners will be held for reciprocity and examination on July 9-10, 1957, at State Capital Bldg., Boise, Idaho. **Board Secretary:** Dr. Alma N. Miller, 301 Kane Bldg., Pocatello, Idaho.

Iowa
The Iowa State Chiropody Board of Examiners will conduct examinations at the State Office Building in Des Moines, Iowa, on June 10-12, 1957. **Board Secretary:** Dr. C. T. Howard, Lippert Bldg., Boone, Iowa.

Illinois
The next board meeting of the Illinois Chiropody Examining Committee will be held for reciprocity and examination on June 17-19, 1957, at 160 No. LaSalle St., Chicago, Ill. **Superintendent of Registration:** Fredric B. Seicke, Capitol Bldg., Springfield, Ill.

Kansas
The Kansas Board of Podiatry Examiners will hold its next meeting for examination on June 5-6, 1957, at the University of Kansas Medical Center, Kansas City, Kansas. **Board President:** Dr. L. E. Krause, 1107 Williams St., Great Bend, Kansas, or Kansas Board of Podiatry Examiners, 872 New Brotherhood Bldg., Kansas City, Kansas. **Board Secretary:** L. F. Schmaus, M. D., 864 New Brotherhood Bldg., Kansas City, Kansas.

Kentucky
The Kentucky State Board of Chiropody meets on the third Saturday and Sunday of June and the first Saturday and Sunday of December each year. The December meeting is for re-examination only.

Maine
The Maine Board of Examiners in Chiropody and Podiatry. **Board Secretary:** Adam P. Leighton, Jr., M.D., 192 State St., Portland, Maine; **Podiatry Examiner:** Dr. Ellsworth C. Reed, 547A Congress St., Portland, Me.

Massachusetts
The next board meeting of the Board of Registration in Chiropody-Podiatry will be held for reciprocity, conditionally, and examination, June and December, at the State House, Boston, Mass. **Board Secretary:** Dr. James F. Dunne, 428 South Street, Hyannis, Mass.

Minnesota
The Minnesota Board of Chiropody Examiners will hold its next meeting on June 20, 1957, at the Minnesota State Capitol in St. Paul, Minn. **Board Secretary:** H. W. Leibold, D.S.C., 221 Hamm Bldg., St. Paul 2, Minn.

Mississippi
The Mississippi State Board of Health. **Board Secretary:** Dr. Felix J. Underwood, Old Capitol, Jackson, Miss.

Missouri
The next board meeting of the Missouri State Board of Chiropody will be held for reciprocity and examination on June 16-17, 1957, at the Jefferson Building in Jefferson City, Mo. **Board Secretary:** Dr. L. A. Hansen, 800 Professional Bldg., Kansas City, Mo.

Nevada
The next board meeting of the Nevada State Chiropody Board will be held for examination on May 6, 1957 at 150 Chestnut Street, Reno, Nevada. **Board Secretary:** Dr. William A. Edwards, 150 Chestnut St., Reno, Nevada.

New Hampshire
The New Hampshire Board of Registration in Chiropody. **Board Secretary:** John S. Wheeler, M.D., 107 State House, Concord, N. H.

New Mexico
The next board meeting of the New Mexico State Board of Chiropody will be held for reciprocity (upon application) and examination on July 13-14, 1957, in Albuquerque, N. M. **Board Secretary:** Morris Haas, D.S.C., 1301 Central Ave., East, Albuquerque, N. M.

North Carolina
The North Carolina State Board of Chiropody Examiners will hold its next meeting for reciprocity and examination on June 22-23, 1957, at Fayetteville, N. C. **Board Secretary:** Dr. Charles Darby, P. O. Box 55, Statesville, N. C.

North Dakota
The next board meeting of the North Dakota Board of Registration in Chiropody will be held for reciprocity and examination on April 21, 1957, at 611 First Ave., No., Fargo, No. Dak. **Board Secretary:** Dr. E. B. Snuff, 611 First Ave., No., Fargo, No. Dak.

Oklahoma
The Oklahoma State Board of Chiropody will hold its next meeting for examination on September 28-29, 1957 at 1217 No. Walker in Oklahoma City, Okla. **Board Secretary:** Dr. Warren D. Long, 1217 No. Walker St., Oklahoma City, Okla.

Rhode Island
The Rhode Island Board of Examiners in Chiropody. **Administrator:** Thomas B. Casey, 366 State Office Bldg., Providence, R. I.

Tennessee
The Tennessee Board of Registration in Chiropody. Board Secretary: Dr. Arthur Richert, 3355 Poplar St., Memphis, Tenn.

Texas
The Texas State Board of Chiropody Examiners. **Board Secretary:** Dr. Lewis M. Hoppock, P. O. Box 3315, Temple Texas.

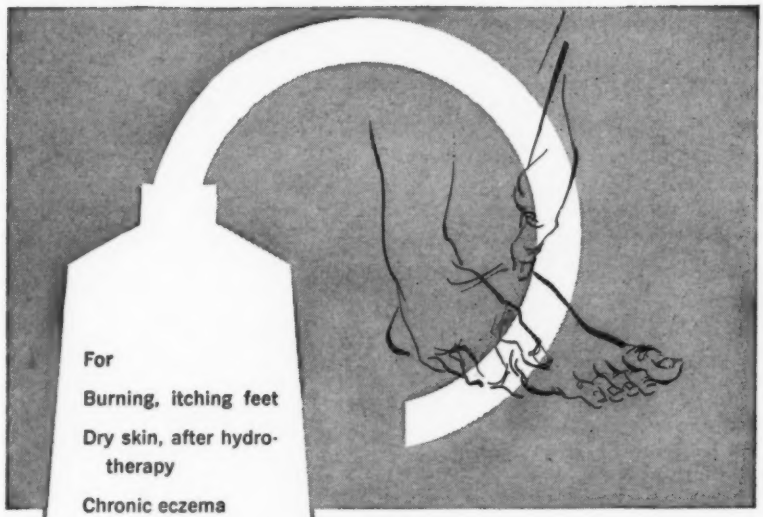
Utah
The next board meeting of the Utah State Board of Chiropody Examiners will be held for examination in July 1957 at the State Capitol in Salt Lake City, Utah. **Board Secretary:** Dr. A. Bowden, First Security Bank Bldg., Provo, Utah.

Washington
The next board meeting will be held for examination, July 1957, at U. of W. Medical School, Seattle, Wash. **Board Secretary:** Edw. C. Dohm, Gen. Adm. Bldg., Olympia, Wash.

West Virginia
Medical Licensing Board of West Virginia. **Board Secretary:** N. H. Dyer, M.D., State Office Building, Charleston, W. Va.

Wisconsin
The next board meeting will be held for examination July 9-10, 1957 at 231 W. Michigan Ave., Milwaukee, Wis. **Board Secretary:** Dr. O. J. Trimborn, 208 E. Wisconsin Ave., Milwaukee 2, Wis.

Wyoming
The Wyoming State Board of Registration in Chiropody will hold its next meeting for reciprocity and examination on June 21-22, 1957, at Capitol Bldg., Cheyenne, Wyoming. **Board Secretary:** Dr. Duane Neuschultz, P. O. Box 1029, Torrington, Wyo.



For

Burning, itching feet

Dry skin, after hydrotherapy

Chronic eczema

Softening calluses, corns, "horny" heel

Soothing after electrodesiccation

Shoe "rub" or chafing

Routine foot hygiene in diabetes

Adhesive tape reactions

Indolent ulcers

Dry, chafed feet

Try

TASHAN CREAM

You'll like it and so will the patient

Tashan Cream soothes, softens, stimulates healing — contains vitamins A, D, E, and *d*-panthenol in a non-sensitizing, cosmetically pleasing, absorptive cream base. In tubes, 1 oz.

Tashan Cream is compatible with most types of other medication indicated.

TASHAN™ Cream

Hoffmann-La Roche Inc Nutley, New Jersey

REGION SIX
MEETING

NEBRASKA, MINNESOTA, IOWA, COLORADO, KANSAS, SO. DAKOTA, MISSOURI, NO. DAKOTA

STATLER HOTEL **ST. LOUIS, MISSOURI**

MAY 3-4-5, 1957

Pre-convention tour and demonstration (Thursday afternoon, May 2) at Firmin Desloge Hospital Chiropody Clinic.

a) Fabrication of the Rosoff sandal

b) Injection therapy of helomata

SCIENTIFIC PROGRAM

Carl M. Fellhauer, D.S.C., M.D. "Children's Orthopedics"
Senior Instructor, Orthopedic Surgery, St. Louis University School of Medicine.
Orthopedic consultant to:
National Foundation for Infantile Paralysis,
University of Missouri Medical School,
St. Mary's Group of Hospitals

Joseph Dollar, D.S.C. "Athletic Injuries Treated by Chiropodists"
Head Trainer, Chicago Cardinal Football Club.
Instructor, Chicago College of Chiropody

Marvin Steinberg, Pod. D., "General Chiropody—Thorough Scientific Evaluation and Treatment of Everyday Chiropody Patients"
Clinical diagnosis, X-Ray, laboratory procedures, effective treatment of problem cases, neo-plastic diseases, rheumatoid arthritis. Problem Clinic. Bring your problem cases.
N.A.C. Science Award Winner—1956
Director, Post-Graduate Education and Research, Podiatry Society, State of New York.
Attending Podiatrist, Jewish Memorial Hospital, New York.

ENTERTAINMENT

Thursday nite, May 2—"Welcome to St. Louis"
Cocktails and conversation
Friday, May 3, A.M.—Registration and get-together
Friday evening, May 3—"Moonlight on the Mississippi"
Dinner and dancing on a river boat
Saturday nite, May 4—"Official Banquet"
Dinner and dancing

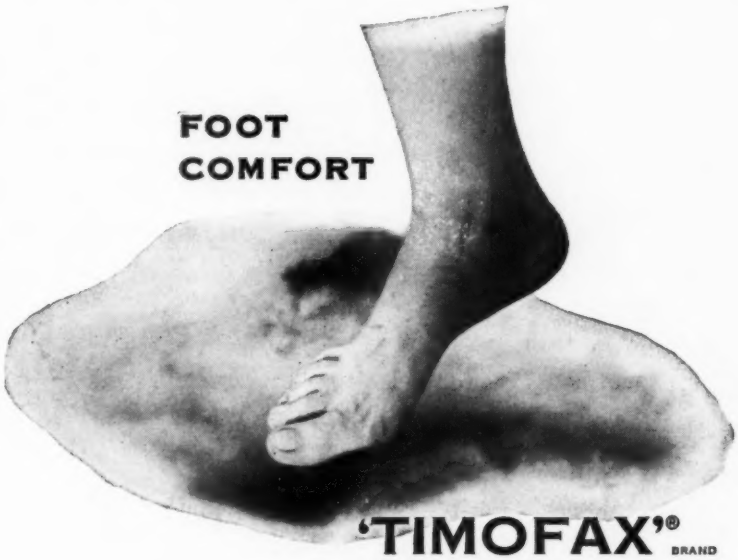
WOMEN'S PROGRAM

Friday, May 3, A.M.—Registration and get-together
Afternoon—Around the World Tea
Saturday, May 4, A.M.—Tour of St. Louis
Luncheon en route at the Montclair

N.A.C. Members Registration $40.00—Women's Registration $10.00
(Registration includes all scheduled luncheons, banquets, etc.)

Mail check or money order to:
K. E. Lane, D.S.C.
1207 Brentwood Blvd.
Richmond Heights, Mo.

Make hotel reservations direct to Hotel Statler, St. Louis, Mo.



FOOT COMFORT

'TIMOFAX'® BRAND

UNDECYLENATE FOOT POWDER

. . . . . to prevent "athlete's foot" and similar fungal skin infections.

Shake 'TIMOFAX' POWDER over and between the toes after every bath or shower.

- Clean smelling
- Stays dry and powdery

1½ oz. shaker-top containers

Also available, for the treatment of "athlete's foot," 'TIMOFAX' BRAND UNDECYLENATE OINTMENT
Tubes of ¾ oz., and jars of 1 lb.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe 7, New York

TO: BURROUGHS WELLCOME & CO. (U. S. A.) INC., TUCKAHOE 7, NEW YORK
DEPT. D 3A

PLEASE SEND ME A SAMPLE OF **'TIMOFAX'** POWDER.

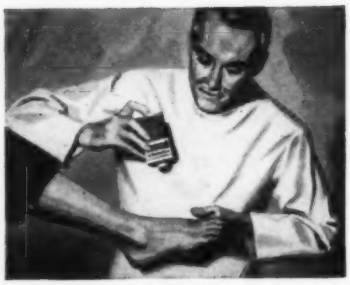
DOCTOR_____

ADDRESS_____

CITY_____ STATE_____

Latest research proves*

Dry fungicidal powder helps prevent athletes foot



Scientific findings confirm greater effective value of powder

Newest experiments endorse powder as an effective guard against Athletes Foot. Researchers report regular use of a drying, mildly fungus-killing powder prevents dermatophytosis. The findings support the popularity of prevention of fungus infection by powder with both doctors and patients.

Many doctors use and recommend Quinsana Powder. Quinsana covers the skin with a powder-barrier that blocks the growth of Athletes Foot fungi. Moist, fungi-breeding cracks in sensitive areas around the toes disappear. Quinsana soothes and cools hot, tired feet while it protects them. Use and recommend Quinsana!

**Experiments conducted under Army grant of Doctors from New York University Post Graduate Medical School and the Skin and Cancer unit of University Hospital.*

Mennen ... *Skin Specialist for over 80 years*

JOURNAL

OF THE

NATIONAL ASSOCIATION of CHIROPODISTS

THE OFFICIAL PUBLICATION OF THE PROFESSION

VOLUME 47 APRIL, 1957 NUMBER 4

A HISTORY OF THE JOURNAL OF THE NATIONAL ASSOCIATION OF CHIROPODISTS

CHARLES E. KRAUSZ, D.S.C., Ed.D.*
Philadelphia, Pa.

THIS issue marks the 50th birthday of the Journal of the National Association of Chiropodists. It was in April 1907 that the Pedic Society Items made its bow to the profession. This little four-page folder was the first chiropodical journal in the world. In 1907 our profession was still in its infancy. Organized state societies existed only in New York, Illinois, New Jersey and Massachusetts. There was no national body to represent our group. New York was the only state which had enacted a chiropody law. There were no schools of chiropody and the embryo practitioner received his training from a preceptor. In many areas it was necessary for patients to travel long distances in order to obtain chiropodical services. Some idea of the total number of practitioners in the United States may be derived from the fact that in 1907 there were only 56 chiropodists in Philadelphia, and 118 in New York.

The Pedic Society Items was edited by Alfred Joseph (1867-1928) and published by the Pedic Society of the State of New York. The officers of the Society at that time were: President, Elliott W. Johnson; Vice President, John T. McDonald; Secretary, Max Nachbar; Treasurer, Harry H. Moore.

In the beginning the journal was published three times a year and contained short articles on foot lesions, state society business and personal items concerning the New York practitioners. The December 1907 issue contained the first advertising matter. The honor of being the first advertisers goes to "Mauger and Schuster, New York, Manufacturers of Orthopedic Appliances," and "Walton Manufacturing Company, New York, Patent Arch Supports." In July 1911, the title of the journal was shortened to Pedic Items and beginning with the January 1912 issue, it was published monthly.

The Pedic Items proved to be the cornerstone of chiropody's development. Through the columns of the journal, Alfred Joseph ably publicized the benefits which accrue from organization. As a result, new state societies were formed in Pennsylvania (1909), Connecticut (1910) and Missouri (1911). On June 6, 1910, Alfred Joseph attended a dinner at the New Windsor Hotel, Philadelphia. One of the speakers at this affair was James R. Bennie, President of the Chiropody Society of Pennsylvania. In his talk, Dr. Bennie mentioned the need for a nationwide organization of chiropodists. This suggestion gave Alfred Joseph the idea which eventually culminated in the formation of the National Association of Chiropodists. The idea of

*Dean, Temple University, School of Chiropody and Chairman, N.A.C. History and Library Committee.

organizing a national body was discussed at several of the New York Society meetings and received conditional approval. As a result, the October 1911 issue of the Pedic Items carried an editorial which outlined the objects of a national group and solicited funds to defray the initial expenses. The response to this editorial was gratifying and it is a matter of record that the following individuals contributed to the project: C. L. Scharaff, O. S. Gruggel, S. Rutherford Levy, H. H. Katz and Maretta Dixon of California; C. A. Seiverd and Anna M. Caswell of Connecticut; L. Nicclaina of Colorado; J. H. Williams of Indiana; Henry Schmidt and Ignace Reis of Illinois; R. Mascaro of Louisiana; Mary C. Benzinger of Maryland; F. W. McCarthy and Joseph M. Cassidy of Massachusetts; F. E. Jilik of Michigan; H. E. Ballard of Minnesota; C. S. Davis of New Hampshire; Charles Hans, A. L. Lipman and L. J. Bird of New Jersey; William Rabenstein, George Turner and H. C. Ford of Ohio; W. M. Chadwick of Oklahoma; Adam Hall, S. Elizabeth Ebright, A. Royer and Julia Gerry of Pennsylvania; A. Lobb of Texas; Bertha and Edna Stocker of Washington; and E. S. Bump of Wisconsin. Group contributions were also made by the state societies of Connecticut, New York and Pennsylvania. Each succeeding issue of the Pedic Items carried additional information concerning the proposed organization. As a result of these efforts, a convention was held at the La Salle Hotel, Chicago, on July 1, 2 and 3, 1912. One hundred eighteen chiropodists, representing twelve different states, were present. This was an excellent registration when we consider that there were less than a thousand practicing chiropodists in the United States at that time. The National Association of Chiropodists was officially organized at the Chicago meeting and the following officers were elected: President, Alfred Joseph, New York; First Vice President, Henry Schmidt, Chicago; Second Vice President, Ernest Stanaback, Newark; Third Vice President, John Betz, St. Louis; Fourth Vice President, William Rabenstein, Cincinnati; Secretary-Treasurer, Ernest Graff, New York.

In common with other branches of the healing arts, chiropody struggled through years of preceptor training. Nehemiah Kenison (1824-1891) established this system to train assistants for his offices in Boston, New York, Philadelphia, Chicago and St. Louis. He personally trained two brothers, one sister, three sons, two nephews, three cousins and at least nine non-relatives during his 45 years of practice. This same instructional method was employed by other early practitioners, such as, John Littlefield and J. Parker Pray of New York, Marcus Goldberg and Horace Fowler of Philadelphia and many others. Alfred Joseph recognized the fact that if chiropody was to gain stature, it was necessary to establish some type of formal education for the profession. The columns of the Pedic Items were again utilized to carry this progressive idea to the membership. As a result, an organization, known as the Chiropodists of America, was chartered by George M. Wedekind, Otto Sjorgen, Ernest Graff, Irvin Mayer, Charlton Griffin, George Erff and Alfred Joseph. This group established a chiropody school which opened its doors on May 22, 1911, at 1245 Lexington Avenue, New York. The original faculty consisted of George Erff, Chief Instructor in Clinical Chiropody; Samuel Kanner, M.D., Instructor in Materia Medica; Gustave Fleissner, Instructor in Physiology and Chemistry; E. Kenneth Burnett, Instructor in Clinical Chiropody; Walter Teskey, Instructor in Mechanical Chiropody and Alfred Joseph, Instructor in Anatomy. The school was moved to 51 E. 125th Street on November 11, 1912, when it was reorganized under the name of the School of Chiropody of New York. Following this, other chiropodical institutions were established in San Francisco, Philadelphia, Chicago and Cleveland.

In 1913 the only states which enjoyed licensure in chiropody were New York, New Jersey and Pennsylvania. The public was frequently victimized by unqualified individuals who took advantage of this situation. The legitimate practitioner was often placed in a bad light by the actions of these imposters. Letters to the editor of the Pedic Items brought many of these cases to light. This stimulated the journal to inaugurate an editorial campaign for legislation in the unprotected states. Resumes of the then existing laws were published along with suggestions concerning the proper approach to state legislatures. These efforts had almost immediate effect and by 1914 both Ohio and Rhode Island passed chiropody laws. During 1915, California, Connecticut and Michigan were successful in their legislative attempts and in 1916, Louisiana, Maryland and Virginia joined the select circle. The year 1916 proved to be the big year for chiropody laws when Colorado, Illinois, Massachusetts, Minnesota, Nevada, Washington, West Virginia and Wisconsin secured enactment of their respective chiropody bills.

The first scientific contributions to the Pedic Items were rather rudimentary in character. As the journal increased in size, the calibre of the articles showed a decided improvement. In many areas the Pedic Items was the only means by which a chiropodist could keep abreast with new methods of diagnosis and treatment. It is interesting to note that from 1907 to 1920, the Pedic Items published 392 separate articles. These articles were contributed by 207 authors. As could be expected, Alfred Joseph wrote the largest number of articles during this period. Others who made frequent contributions at this time were: E. Kenneth Burnett, Reuben Gross, W. Ashton Kennedy, Andrew H. Montgomery, Ignace Reis, Eugene Rice and Otto F. Schuster. There is no question about the fact that the writings of these men were a great inspiration to the profession during this era. Of particular interest were the articles on foot orthopedics by Otto Schuster (1881-1936). He was responsible in a large measure for the entrance of the chiropodist into the corrective field.

The success of the Pedic Items provided the stimulus for the creation of other chiropodical journals. Being the only journal in the field, it had a wide circulation in Great Britain. When the English chiropodists organized their society, they decided to sponsor their own journal. It was called the Chiropodist and the first issue appeared in January 1914. It was published in London and edited by Ernest G. V. Runting (1861-1954). This journal is now the official organ of the Society of Chiropodists, Ltd. From November 1915 to December 1916, a monthly paper appeared under the name of the Chiropodist's Journal. It was published by W. L. Dudley of New York and edited by H. Howard Levy, Jr. The first meeting of the Pedic Society was held in 1895 at the office of Dr. Levy. The first issue of the Podiatrist appeared in January 1917. It was edited by E. Kenneth Burnett of New York. It was published monthly until December 1920. The Podiatrist was discontinued when Dr. Burnett became the editor of the Journal of the National Association of Chiropodists in January 1921. The Chiropody Record entered the field in May 1918 and was founded by officials of the Illinois College of Chiropody.

Although the Pedic Items was the property of the Pedic Society of New York, it was Alfred Joseph who did all of the editorial work and the soliciting of advertisements. The matter of adequately reimbursing the editor became a problem. After considerable discussion, the State Society voted to turn over the ownership of the

journal to Alfred Joseph. This occurred on March 11, 1913. He continued to operate it as a private enterprise until 1920. At the annual N.A.C. Convention held at the Hotel Adelphi, Philadelphia, on August 2, 1920, it was decided to purchase the Pedic Items. It was renamed the Journal of the National Association of Chiropodists beginning with the January 1921 issue. Since that time, it has been the official voice of the profession.

Alfred Joseph's good work was continued by his editorial successors. E. Kenneth Burnett of New York served as editor and business manager from 1921 to 1930. From 1931 to 1941, Joseph Lelyveld of Rockland, Mass., was editor and Arthur R. Morley of New York was business manager. William J. Stickel held both the editorial and business manager portfolios from 1942 to the time of his death in July 1955. Our present staff is composed of Abe Rubin as editor and Franklin Fielding as business manager. As we observe the Golden Anniversary of chiropody's first publication, we can realize that our profession has progressed far beyond the expectations of those who created our journal just fifty years ago. We are proud of our past history. We look forward to the future with a full realization that chiropody is still the hope of a footsore world.

926 W. Lehigh Ave.

A NEW RESILIENT PLASTIC FOR ORTHODIGITAL PROSTHETICS

S. C. SIVITZ, D.S.C.
Lewistown, Pa.

For the best results with our orthopedic devices, we cannot use the negative impression-positive model-molded end result system that is typical of dental prosthetic devices. Because of the varied spatial and joint positional considerations of the foot when ambulatory and covered with a shoe, our impression material, molded while the patient is walking should also be our end result. Practical and clinical experiences have proven the necessity of this one stage technic.

Thus, the properties and characteristics of plastic materials that may be of value to us can be defined as follows:

1. Self-polymerizing, or curing, at room temperature.
2. Absence of chemicals irritating to the skin that cannot be controlled by a topical skin barrier. Not have a noxious odor.
3. Measurable and miscible with instruments reasonable for a chiropodist's office.
4. Must have a "dough" state or working period of time of about two to five minutes.
5. Must be hydraulically responsive dur- its "dough" state.
6. If thermo-setting, it must be within skin or environmental tolerance.
7. The end product to be a flexible, resilient, durable plastic.

With the generous cooperation of the Vernon-Benshoff Co., the invaluable advice of Dr. Albert Pincus, and the experimental assistance of numerous colleagues, I have developed a resilient acrylic plastic resin that meets those requirements.

Chiropody Resin #61956®[1] appears to be of merit for orthodigital prosthetics.

Acrylic Plastics are most familiar to us as "Plexiglass" and, in colored form, for dentures. These acrylic plastic resins will remain hard at ordinary temperatures, although, as you may know, they can be softened by high temperatures. They can be molded very exactly and are not affected

[1] ® Vernon Benshoff, P. O. Box 1587, Pittsburgh 30, Pa.

by most acids, alkalis or solvents.

In this form, these plastic resins are processed by mixing them with a chemical that contains oxygen (in the form of an organic peroxide). Then under the influence of heat and pressure, the plastic is polymerized.

Polymerization can be roughly described as the process of taking the individual separate links of the plastic resin and joining them into an unbroken solid chain.

It was discovered that a catalyst could be added to the mixture so that the process could be made to occur at room temperature without pressure. This self-polymerization enables us to use these plastic resins for our nail work and orthopedics.

The polymerization reaction is accompanied by the evolution of heat, the degree of temperature depending on (a) the volume of dough present, (b) the ambient or room temperature. The higher the ambient temperature the more rapid the polymerization reaction and the higher the peak of exothermic heat. Using a small amount for a nail groove or nail cap, this exotherm is so small that it is not critical. Where large amounts are used, as for a heel cup or toe shield, special ingredients should be added to delay the rate of polymerization and thus reduce the amount of heat given off at any moment. You may have had some experience with the acrylics that have not been so modified, and when used, have given the patient a real hot foot.

Not all acrylic compounds have such high softening points as plexiglass or dentures. There are some that will be soft at room or body temperature. It is these that we use as resilient acrylics for crests, toe shields, etc.

Materials

1. Resin Components. Vernon Chiropody Resin #61956.
2. Measuring spoons or c.c. measuring vials.
3. Small 1 oz. mixing bowl or ointment jar, etc.
4. Small spatula (dental supply).
5. Timer.
6. Plastic film bag, Saran Wrap or wettable cellophane (preferred).

Acrylic resins are marketed in two components—liquid (monomer) and powder (polymer). In these ingredients are incorporated a promotor and a catalyst system to induce self-curing (polymerization) of the slurry or dough formed by the mixture of the two ingredients. In their own tightly capped containers, the resin components have a long shelf-life.

For consistent results, store the resins and the mixing cup at room temperatures (65-75 F.) away from hot radiators and cold windows. Lower temperatures will prolong the curing time, higher temperatures will hasten it.

Suggested Volumes:

One crest—2 teaspoonfuls of powder to one teaspoonful of liquid.

Bilateral crests—1 tablespoonful powder to two teaspoonfuls of liquid.

H. D. device—1 teaspoonful powder to ½ teaspoonful of liquid.

Bunion shield—2 teaspoonfuls powder to 1 teaspoonful of liquid.

Equivalents—(all level measurements)

1 tablespoon equals 15 cc. equals 4 teaspoon equals ½ oz.

Procedure

1. Measure (accurately) one volume of liquid, add two volumes of powder. A separate measuring vessel should be used for each, and the liquid vessel left upside down to drain and keep clean.

2. Stir ingredients until dough frees itself from sides of jar.

3. Apply water to your hands so that the

plastic will not stick to them while handling it.

4. When the plastic resin is no longer liquid, and is not sticky, and does not come away in strings from contact with the spatula blade; that is the end of the (a) slurry stage.

5. Shortly before that time, the resin can be removed from the mixing bowl with the spatula, rolled in the palms, shaped into the approximate form desired and applied to the foot or toes. This is the beginning of the (b) dough state.

6. As retainers for crests, when applying the plastic dough, separate the 1st and 3rd interdigital spaces and press a little dough between the toes. This will mold as two "collar button" extensions.

7. Cover the area with a wetted cellophane or plastic film.

8. Apply patient's shoes and have him walk around the waiting room. Estimating the time when the patient should ambulate will come with experience and by judging a small sample of the mix. Depending upon the particular device and the foot involved, it may be earlier or later in the dough state. In any event, dynamic functional molding is imperative. The most probable error in the entire procedure will be too early ambulation. Do not be too hasty.

9. The initial set (c) period can be judged to be completed when a sample will no longer maintain deformation. The entire cycle requires 15-25 minutes.

a. Slurry	5 - 8 minutes
b. Dough	5 - 8 minutes
c. Initial set	5 - 8 minutes

Like other self-curing acrylics, complete polymerization requires about 24 hours. In those cases where some dimensional changes might occur if the device is removed immediately after the initial set is completed; leave it on for 2 to 4 hours.

Discussion

The monomer and polymer are easily miscible. The relative proportions of liquid to powder are very important in order to produce optimum chemical reaction and an end product of proper resilience. In general, the higher the proportion of liquid in the mix, the softer the end result and vice versa. However, it is not advisable to depart too far from the recommended powder-liquid proportion because of the possibility of obtaining incomplete polymerization in the end result.

Extreme ambient temperatures will critically affect the speed of the reaction. If the room temperature should be too high, the bottles containing the resin components, the mixing bowl and the spatula should be chilled in a cold water bath before use. Conversely, if the reaction is occurring too slowly, it can be hastened by warming the dough in water or with a hot air blower.

The material may be built up, i.e., new added to old, as it welds to itself successfully.

After curing, the material has a mild but not noxious odor, which dissipates in a few hours.

Crest Therapy

The ideal crest should (1) contact all possible skin surface on the plantar of the toes; (2) fill up the entire space (no more, no less) that exists under the toes; (3) stay in place without interference to toe function; and (4) its presence should be unnoticed by the patient, and certainly not be annoying during normal gait.

A crest produces functional extension of the toes by neuromuscular stimulation, primarily. Mechanical "blocking up" of the toes will not produce equivalent, lasting physiologic effect. Therefore, do not force too much mass under the toes. Especially at the start, do not attempt to develop more space under the toes than can be

observed in the foot at rest. This is more important under 1st, 4th and 5th toes, (in certain foot types) unless other concomitant mechanical therapy is used.

As retainers for crests, when applying the plastic dough, separate the 1st and 3rd interdigital spaces and press a little dough between the toes. This will mold as two "collar-button" extensions.

Heloma Molle

Although a separate smaller device has been reported to be successful, molding one of the crest retainers (described above) in the space involved, may be the best technic.

Heloma Durum and Bunion Shields

As with any other digital devices for helomatadura, bunion, etc., do not remove callous before molding. On the other hand, the practice of adding an artificial increase to the lesion (moleskin, adhesive felt, etc.) is not a sound functional idea.

These devices need not encircle the digit. Dynamically molded to the contours involved, they fit extremely well and the sock or stocking is sufficient to hold them in position.

As in all orthopedic therapies, it is imperative that the basic etiologic functional cause be given adequate consideration for the best results.

In those digital lesions where specific problems (imbalance, hypermobile segments, etc.) exist, this problem must be adequately treated before the digital therapy can succeed.

The toes are part of coordinated extremities. Neither toe problems nor toe treatments can be considered as entities distinct and separate from the rest of the foot and leg.

Summary

An acrylic plastic resin, that produces a rubbery, resilient end product, has been described and the technic for its use outlined. This plastic, Vernon Chiropody Resin #61956,® [1] was developed during the course of several years of experimental therapy. It has been tested clinically by many chiropodists in several hundred orthodigital prosthetic devices, including crests. These men agree that Resin #61956 has a place in the practice of chiropody. Precautions for orthodigital prosthetic therapy are noted.

27 N. Brown St.

People who are wrapped up in themselves make small packages.

Benjamin Franklin

HALLUX VALGUS AS RELATED TO THE FIRST METATARSAL LENGTH PATTERN*

HAROLD M. PLASTER, D.S.C.
Joplin, Mo.

THE following findings and related subject matter concerns research started eight years ago to determine what (from a structural viewpoint) influenced the formation of a hallux valgus. While normal structural or architectural variances may be etiologically a factor in valgus, our concept and original belief that a short first metatarsal, more often, played a part in this distortion has been fairly well borne out by the statistics of this effort.

The basis of this paper follows the assumption that man was originally intended to be a barefoot walker, intended to walk on softer uneven terrain wherein all parts of the foot could fulfill their normal functions.

This paper is a consideration of just the forefoot of man in his present environment of even, hard, unyielding walking surfaces, with emphasis on the first metatarsal segment.

In evaluating the following, the mechanics of walking, particularly the thrusts of the forefoot in the final phases of the step, must be constantly borne in mind.

The most perfect foot free from distortion of the forefoot (in metatarsal-phalangeal segments) is found wherein the 5 metatarsal are of near equal length. These feet are not too frequently seen in our offices, except for occasional direct trauma or stress of contour. These feet are more adaptable to even walking surfaces because of their more equal metatarsal length pattern.

The function of a metatarsal head is primarily one of weight bearing. The function of the digits is threefold; balance, grasping and propulsion. Add weight bearing

Fig. 1. Metatarsal length, pattern three planes.

Fig. 2. Plastic measuring device being used.

*Award Winner, William J. Stickel Annual Awards for Research (awarded posthumously).

TABLE I

	Number	Percent		Number	Percent
Long first metatarsal	2192	43.63	Moderate, long first metatarsal	616	12.26
Short first metatarsal	2769	55.10	Moderate, short first metatarsal	843	16.80
First and second metatarsal equal	62	1.23	Severe, long first metatarsal	583	11.60
Total valgus	4227	84.01	Severe, short first metatarsal	767	15.26
Valgus with long first metatarsal	1797	35.77	No valgus, 405 cases, first metatarsal longer		8.08
Total cases showing valgus with short first metatarsal	2249	44.79	No valgus, 391 cases, first metatarsal shorter		7.07
Incipient H.V.	1228	24.44	Number of male	1533	30.32
Moderate H.V.	1459	28.82	Number of female	3490	69.48
Severe H.V.	1350	26.87			
Incipient, long first metatarsal	589	11.90	Total	5023	
Incipient, short first metatarsal	639	12.72			

Fig. 3. Normal alignment no valgus of hallux.

to these three functions of the digits and distortion with its accompanying sequelae will utimately follow. If a metatarsal be extremely short, its accompanying phalangeal segment must assume part or all of its intended function. Figure 1 shows a metatarsal length pattern presenting three separate planes. Metatarsals 2 and 3 are of nearly equal length. Metatarsals 1 and 4 are of nearly equal length. Metatarsal 5 has a plane approximately one inch shorter than metatarsals 2 and 3. Note incipient valgus of 1st segment and marked varus of 5th segment. (This patient presented herself for treatment of a chronic heloma durum on 5th digit, where lines 1 and 4 bifurcate).

The following method of measurement of the first metatarsal was employed in this research:

With a clear plastic measuring device with 1/16 inch markings, the second metatarsal is bisected (Figure 2).

The length of the second metatarsal is used as the standard in determining the longness and shortness of the first metatarsal.

Fig. 4. Incipient valgus of hallux.

The amount of valgus of the proximal phalanx to its related metatarsal is determined by bisecting the first metatarsal shaft and extending the line through the phalanges. (Figures 3-4-5-6).

All x-rays were taken uniformly, on weight bearing and 30-inch target.

There was valgus present in 62 cases where the first and second metatarsals were of equal length. The shortest first metatarsal as related to the second metatarsal was, in three cases, ½" shorter (severe valgus). The longest first metatarsal as related to the second metatarsal was ⅝" longer (no valgus). Of the total cases 471 showed fractured or bipartite sesamoids. The bulk of these showed varying degrees of valgus, 38 being normal 8.06 percent.

General Considerations

The percentage of valgus is greater where the first metatarsal is shorter than the second.

The percentage of total valgus is great—84.01. The bulk of incipient cases, however, were asymptomatic.

The percentage of valgus in long first metatarsals 1797 as related to the total of long first metatarsals 2192 was 80.16.

The percentage of valgus in short first metatarsals 2249 as related to the total of short first metatarsals 2769 was 84.87.

The incidence of injured sesamoids is much higher in the cases showing long first metatarsals. This being the case the percentage of valgus in the long metatarsal cases can partly be attributed to the above fact.

While valgus presents itself when the first metatarsal is longer, this in part can be attributed to the popular "Whipping Boy" short foot gear. Direct trauma from such

Fig. 5. Moderate valgus of hallux.

Fig. 6. Severe valgus of hallux.

foot gear is no doubt a causative factor in some of these cases; but the somewhat popular conception that ill-fitting shoes are responsible for all bunions is a myth.

Most metatarsals if excessively short will present hypermobility. This is most frequently found in the first and the fifth, and rather infrequently in the three middle metatarsals. Hypermobility of a metatarsal comes about if that metatarsal and its head, due to shortness, is unable to fulfill its proper function, weight-bearing.

The preceding percentages show about one male to every two females (30.32% to 69.48%) has hallux valgus.

The fact that only 62 cases of this total showed first and second metatarsals of equal length is worthy of mention. That no valgus existed in any of these 62 cases seems incredible.

Conclusion

This paper is presented for its statistical value only. The application of accurate accommodative measures to insure a metatarsal line corresponding to even walking surfaces presents a difficult problem to chiropody.

Combining all the factors involved and evaluating carefully, we may soon evolve an accurate solution to the many variances making for forefoot distortion.

Acknowledgment

I wish to gratefully acknowledge assistance given me in the task of measuring these films by my able assistant, Mrs. Kay Plummer, for the excellent photography by Mr. Murwin Mosler, and the many hours of compilation and typing by my wife.

316 Frisco Building

We are always looking to the future; the present does not satisfy us. Our ideal, whatever it may be, lies further on.

Gillett

ROENTGENOLOGICAL CONSIDERATION OF THE METATARSUS

BERNARD D. SHERMAN, D.S.C., F.A.S.C.R.
Stratford, Conn.

Part I

DURING the last three decades, the science of roentgenology has been put to use by practically every branch of medicine as a necessary diagnostic aid. In the last twenty years our profession has developed the use of the X-ray for the purpose of examining and diagnosing structural foot defects and pathological problems to a high degree of efficiency.

Our profession has developed standardized technics for radiographing the foot on weight-bearing. By these procedures the chiropodist can determine the static and dynamic condition of the foot and any degree of weakness or deformity can readily be visualized.[1] He can readily confirm any changes which have occurred in soft tissue or osseous structures of the foot. Whatever may or may not be disclosed, no investigation is complete unless it includes radiographic examination of both feet.

It is the author's opinion that metatarsal and related digital problems account for the majority of our patients' complaints. The term "metatarsalgia" is as ambiguous to the chiropodist as "eczema" is to the dermatologist, and should be eliminated from our terminology.

Since every practitioner is familiar with the normal radiographic appearance of the metatarsus, and with the usual discrepancies frequently seen in the length patterns of these bones, this phase will not be reviewed.

General Consideration of the Normal Metatarsus

Radiographic Appearance of Normal Bone

Bone: contrasts sharply with muscle, blood, fat and air because its calcium, present as complex phosphate salt, strongly absorbs X-rays of the wavelength used in diagnostic roentgenology. In the long bones, such as the metatarsals, the densest part of the cortex casts a structureless X-ray shadow except for grooves, ridges and nutrient canals. The shadow is broad at the center of the shaft, but narrows to a thin line at the periphery of the cancellous bone forming the metaphysis.

Cancellous Bone: appears as a fibrous network corresponding to the primary and secondary trabeculae.

Periosteum: under normal conditions, has the same density as the surrounding soft tissues, and does not show in the X-ray. When it is disturbed by trauma, hemorrhage or neoplasms, and retains its osteogenic powers, the resulting "periosteal new bone" has a characteristic appearance.

Cartilage: also has the density of surrounding soft tissue, and in the normal adult foot is ray transparent.

Synovial Membrane and Joint Capsule: under normal conditions are also ray transparent.

Soft Tissues: where they are not always clearly defined, must be considered in our roentgen criteria: the condition of the musculature, evidence of atrophy or hypertrophy, deviation of muscles and tendons, age factor of the patient indicated by blood vessel calcification, obliteration of fascial planes due to inflammation or edema, any abnormal tumefaction, etc. With proper radiographic technic, it is possible to study practically all the tissues in and about the metatarsal region of the foot.

The Epiphyses

The epiphyses are so important that it is imperative the chiropodical roentgenologist be familiar with their location,

appearance and method of development. The epiphyses of the metatarsals are similar to those in the metacarpals. The first metatarsal bone usually has a proximal epiphysis, while the second, third, fourth and fifth have only a distal one. Ossification centers for these bones appear between 3 years and 8 years, and fusion with the diaphysis in the female takes place between the ages of 15 and 17 years, while in males, not until 17 to 22 years.

Occasionally so-called "pseudo epiphyses" are seen in the proximal ends of the 2nd and 5th metatarsals, and in the distal end of the 1st metatarsal bone. These are not actually "false" epiphyses, but normal centers in areas not usually having a center of ossification. They are now more accurately referred to as "inconstant epiphyses." An epiphysis at the base of the 5th metatarsal bone in adult is called "os vesalianum."[2]

Sesamoid Bones

The following sesamoid bones are regularly met with: 2 under the 1st metatarsal head, bi-partite or tri-partite. 1 or 2 under the other metatarsal heads. There are several conditions which may produce symptoms in the sesamoids: Trauma (sesamoiditis), Osteochondropathy of 1st medial sesamoid. In the late stages, the bone appears stippled. Fractures of these bones are occasionally seen.

Supernumerary Bones

Occasionally between the base of the 2nd, 3rd and 4th, but more often between the 1st and 2nd metatarsals are found supernumerary bones called "os intermetatarsum." These should not be confused with calcified arterial plaques. The "os vesalianum" appears in the adult foot. It may appear as a single bone, multiple like buck shot, or as small irregular overlapping bones resembling a giant cell tumor.[2]

Generalized Alterations in Bone Density

In referring to specific bone pathology, we shall make constant reference to reduction or increase in the density of bones . . . the patterns of density changes being more or less characteristic for each disease.

Protracted disuse produces definite changes in both growing and adult bones known as disuse atrophy or osteoporosis. This is a normal physiological process resulting from disuse of any bone, either voluntary, from immobilization, or enforced from pain due to some disease process.

Osteoporosis occurs in the metatarsals as part of a generalized condition throughout the foot following immobilization due to a fracture,[3] or infection in a neighboring part. The calcium disappears first from the cancellous bone and last from the dense surface layers of the cortex. The shadow of articular cortex is preserved, and the joint space is not narrowed. These facts assist in the differentiation from the atrophy of arthritis. X-ray findings in senile osteoporosis are similar to those of disuse atrophy.

Osteosclerosis, literally, means "hardening of bone." It is a vague title, and we prefer to use the terms eburnation and condensation. In the metatarsals we find condensing osteitis.

In Albers-Schonberg's disease sometimes called "marble bones," the bones cast an abnormally dense shadow, and yet may be soft as chalk. The reverse may be true in late forms of osteopsathyrosis, where the bones are extremely hard and brittle and yet their X-ray density is normal or less than normal.

Congenital Anomalies and Developmental Malformations

From the comparative anatomy standpoint, we are interested in certain localized anomalies. Occasionally they amount to clinical problems.

a. Supernumerary metatarsals
b. Polydactylism
c. It is a common occurrence to find in the cancellous bone of the tarsals and occasionally in the metatarsals in late adoles-

cence or adult life, one or more isolated nodules of bone called Solitary Dense Bone Islands (compact islands).[4] These should not be confused with chip fractures or accessory sesamoids.

d. Absence of one or more metatarsals

e. Chondrodystrophia foetalis (achondroplasia). The typical chondrodystrophic dwarf with long face, sunken nose and short but usually powerful arms and legs, is a familiar circus figure. The metatarsal heads present a pronounced clubbed appearance, in addition to congenital shortening of several metatarsals.

f. Osteopoikilosis or "spotty bones" or osteopathia condensans disseminata. This condition is seen in the metatarsal bones and is characterized by large numbers of small, dense bone islands in otherwise normal cancellous bone. They are localized areas of bone condensation, and are nonpathologic.

g. Chondrodysplasia is a condition occurring in the metatarsals in which there is limitation of joint function due to mechanical interference by osseous bridgings.

h. Synarthrosis or synosteosis is a metatarsophalangeal or tarsal-metatarsal fusion.

i. Metatarsus primus varus is a congenital condition in which the 1st metatarsal segment is bent inward at the tarsal-metatarsal articulation.

j. Metatarsus primus valgus is where the 1st metatarsal segment is in a valgus position.

k. Metatarsus atavicus is an unusually shortened 1st metatarsal.

(Ed. Note: Parts II and III will appear in the May and June issues respectively.)

It takes as much energy to wish as it does to plan.

Schiller (Iowa) Herald

FACTORS IN THE USE OF THE X-RAY MACHINE

JOSEPH SETTLER, B.S., D.S.C.*
Skokie, Ill.

THIS review is being presented with a view to recalling to the busy practitioner some material he may have forgotten, or bringing to his attention something he may have overlooked. Perhaps he will discover how to better utilize his x-ray equipment.

Part I

X-Ray Production

One of the most interesting episodes in the history of modern science was the discovery of x-rays by Wilhelm Konrad Roentgen in 1895. While working in the laboratory at the University of Wurzburg, Roentgen was studying the green fluorescent stage of the electrical discharge in a Crookes tube. In the gloom of the room he noted that some crystals of barium platino-cyanide fluoresced when the tube was discharged. He repeated the experiment with the Crookes tube completely covered with black paper. The barium platino-cyanide crystals still continued to fluoresce. Roentgen reasoned, therefore, that some invisible yet penetrating rays of an unknown kind were given off by the discharge of the tube.

In the experiments that followed Roentgen found that the rays were coming from the glass walls of the tube itself and, in particular, from the region where the most intense part of the cathode beam was striking the glass. It was to these rays that he gave the name x-rays.

The Crookes tube that Roentgen used in his work bears little resemblance to the x-ray tubes in use today. However, the basic concept of x-ray production is still the same. There are three things which are essential to their production. First, there must be an available supply of electrons; second, they must be released from the source of supply and third, they must be stopped with great suddenness.

To properly understand how these three factors may combine to produce x-rays, we must not only have knowledge of the construction of the tube, but also a knowledge of the spectrum to which x-ray belongs.

According to the theory of James Maxwell and later augmented by the work of Heinrich Wertz, there are physical energies existent in our universe called electromagnetic radiations. These energies combine to make up the electro-magnetic spectrum. The spectrum is made up of radiations that vary from electric waves, which have a length of 3,200 miles, to cosmic rays which may be as short as one trillionth of an inch. All the spectrum consists of electric waves (which are the longest), radio waves, infra red rays, visible light, ultra violet rays, x-rays, gamma rays and cosmic rays. In spite of the great variance in wave length all of the waves travel at the same speed in a vacuum, 186,000 mi/sec. Although their velocities are the same, their properties are not. A striking example of this is the response of the human eye. Of the entire spectrum only one very narrow band can be seen (the visible spectrum). The rest are invisible.

X-rays occupy a position in the spectrum which places them between very short ultra-violet rays and very long gamma rays. The wave length in the x-ray band may vary from long rays, which are 10^{-6} cm in length, to short rays which are 10^{-9} cm in length. It should be noted at this time that those rays which have the shortest wave lengths are the rays which have the greatest powers of penetration.

Just as light may be produced artificially by heating metals to incandescence, so too can x-rays be produced if the three factors

*Instructor, Illinois College of Chiropody.

mentioned earlier are adhered to. In order to coordinate these three factors most effectively the Coolidge or hot cathode tube was developed.

Basically the tube consists of two parts encased in a vacuum and connected to the terminals of a high voltage transformer. These two parts are the cathode, or negative pole, which acts as a filament and an anode or positive pole which acts as the target. When an electric current is sent through the cathode it would ordinarily flow to the anode (providing there is a difference in potential). However, between the cathode and the anode there is a space. Since there is no direct connection between cathode and anode, the flow of current cannot be carried on. To understand how this difficulty is surmounted, one must assume a prior knowledge of electricity. However, in the explanation of the electrical phenomena lies the explanation of x-ray production.

The production of electricity is based on the availability of free electrons in the material through which the electricity is to flow. Therefore, the greater the number of electrons the greater the amount of electricity. The amount or quantity of electricity is called the current, and the current is measured in amperes. The flow of this current, that is to say, the ability to move this current from one point to another in an electrical circuit, is dependent upon the existence of a difference in potential between the two points. This may be likened to the flow of water through a hose. The water always flows through the hose from the point of greater pressure to the point of lesser pressure. As long as a difference in pressure exists the water will flow. This difference of electrical pressure is called difference in potential. The potential difference is measured in volts.

To produce abundant x-rays very little current is needed. Therefore, the current used is measured in milliamperes. A milliampere is one thousandth part of an ampere. Conversely tremendous voltages are needed to produce effective x-rays. The voltage is measured in kilovolts. There are one thousand volts to one kilovolt.

To produce the high voltages and low amperages necessary for x-ray production is the task of the step-up transformer. The transformer is inserted in the x-ray circuit so that the ordinary 110 or 220 volt line, which is the source of our electrical energy, may be converted to the thousands of volts needed for good radiography. The transformer is a metal core around which there are several hundred turns of fine copper wire. The current enters one end of the coil at which there are fewer turns of wire. This part is called the primary coil, and leaves from the other end of the coil, on which there are many more turns of wire, This is known as the secondary coil. In the process of transfer from primary to secondary, the current is stepped up to the desired amount.

When the x-ray machine is turned on, a small amount of current under low voltage is sent to the filament, causing it to heat to incandescence. The filament, which is made of tungsten because of its high melting point, provides the electrons. These electrons are given up by the atoms of tungsten due to the increased molecular activity that the heat represents. The electrons which carry a negative charge would ordinarily leave the cathode and flow toward the anode if a direct connection existed between the two terminals. However, the space between cathode and anode in the tube acts as a barrier to this flow. In order to bridge this gap the electrons must be pushed off with tremendous force. When the tube is energized the transformer builds up a charge of many thousands of volts. The pressure on the cathode becomes so great that the electrons are pushed off into space and propelled toward the anode. In the short distance that they

travel the electrons attain a velocity of from 60 to 90,000 mi/sec. As each electron (having a mass of $9x10^{-28}$ grams) collides with the anode a shock wave is set up. This shock wave that may have a length of from one to ten Angstrom units falls in the x-ray portion of the electro-magnetic spectrum.

It can easily be understood from this that the greater the kilovoltage the greater the force with which the electron will be thrust from the cathode. This in turn means that the velocity attained will be greater, which in turn means the collision between electron and anode will be more violent. Which again in turn means a greater, more intense shock wave of shorter length. We might state the above more simply in this fashion: The higher the kilovoltage, the greater the velocity of the electron; the greater the velocity of the electron, the shorter the wave length; the shorter the wave length, the greater the penetrating power.

When the electrons leave the cathode they are directed or focused to a point on the anode which is known as the target. The target is a small button of tungsten which is usually imbedded in a copper rod, the face of which is placed at a 45 degree angle to the filament. The copper anode is more properly termed the stem. The small target area or point from whence the x-rays emanate is known as the focal spot. This spot may be either 2.4 or 4.2 millimeters in size. The angle of the target and the small size of focal spot make for better control of the x-rays. Any other arrangement would increase the hazard of scatter radiation, because the angle at which the electrons strike the target governs the angle at which the x-rays come off. Then too, not all of the electrons travel at the same speed, nor do they all strike directly on the target area. Only one tenth of all electrons travel at sufficient speed to produce x-rays. Of these only one tenth are effective x-rays. This means the greater majority of the electrons strike the glass walls of the tube or the stem. It also means that the kinetic energy of these electrons is converted to non-effective rays and to heat. One of the functions of the copper stem is to conduct this heat to the various types of coolants which are used around the tube (water, air or oil). I may add that those electrons which do produce effective rays, also dissipate their energy in the form of heat. The heat-absorbing capacity of the tube is the thing which governs the exposure that a tube will tolerate. Manufacturers usually enclose a tube tolerance chart with each tube. This chart shows the maximum exposures which may be safely used for that tube.

(Ed. Note: Parts II, III and IV will appear in the May, June and July issues respectively.)

"An expert is a man who avoids the small errors as he sweeps on to the grand fallacy."

Benjamin Stollberg

CLINICALLY SPEAKING

A place for the more informal presentation of reminders, suggestions, notes, observations and technics of value in office practice. Your contributions of short manuscripts or illustrative case histories will determine this section's usefulness.

TREATMENT OF HELOMA DURUM WITH CRYOTHERAPY

R. L. MORGENSTERN, Pod. D.*
Manhattan, Kansas

In the past, cryotherapy has been proven beneficial in the treatment of plantar verruca and in verruca vulgaris. The same principle has been applied by this clinic* to applicable cases of helomatadura. Most of the helomatadura treated by this method were of five months duration or longer.

From the studies done here, it was deemed necessary to divide the helomata into two distinct groups for purposes of treatment.

Dorsal Heloma Durum

This division comprises all the helomatadura which are on the dorsum of the foot and by consequence of location have an etiology which is more of friction, constant or intermittent, rather than friction and pressure.

Plantar Heloma Durum

This division comprises all the helomatadura found at the lateral margins of the foot and all the plantar deep seeded tylomata, which will be found in many instances under the generalized plantar tyloma.

The dorsal heloma group is more amenable to this method of treatment. This is due to pressure being involved in the etiology of the Plantar Heloma Group and has to be contended with.

At the first visit the heloma was treated with a routine paring and application of 75% silver nitrate[1]. At this initial visit the patient was questioned as to the history of frostbite (any cold injury), occlusive arterial diseases, edema, varicose veins, diabetes, infection in the area and anything that the clinician felt would not warrant the application of cryotherapy.

After the first treatment, an outline of what is going to be done is presented to the patient and a return appointment is made for one week. At the second visit the silver nitrate eschar is removed. All factors being favorable at this time, cryotherapy is inaugurated. The heloma is pared as much as possible without producing hemorrhage. A carbon dioxide pencil is made which at least covers the area of the heloma. The application of the carbon dioxide pencil is for a 60 to 90 second interval with pressure, depending on the depth of the heloma and the width of the surface. After the carbon dioxide application, the patient is advised as to what sensations would follow. The average report of the patients treated at this clinic has stated that the sensations were those of tingling and burning for a duration of any time from 15 minutes to 5 hours.

A protective doughnut type padding is applied and the patient instucted to return in four days. At no time is the patient to rupture the bulla that should form. If the bulla ruptures of its own accord, the patient is to return to the clinic as soon as possible or the walls of the bulla will adhere and the entire treatment is of no value.

The bulla that is formed will be deeper than the average bulla that is formed due to friction. There will be no visible signs to show the patient that there is a bulla present. When the patient returns and the dressing is removed, a fluid mass may be observed and palpated incorporating the

* Foot Clinic, U.S.A.H., Ft. Riley, Kans.

[1] This was found the most beneficial of all the silver nitrate strengths.

entire area of the heloma. The patient may complain that toward the end of the last day or so there may be a throbbing in the area of the heloma. This has been found in a minority of the cases treated at this clinic.

Applying sterile technique the bulla is incised and drained. The entire roof of the bulla is debrided to its attachment at the normal tissue edge. When the debridement is completed, a clean, red, raw healthy tissue base is observed. This will be found under the area where the heloma had existed. The base of this "intentional ulcer" is gently scraped with a scalpel blade to remove any loose tissue. A sterile dressing of Bacitracin® is applied and the patient instructed to return in 48 hours.

This 48-hour check is for the observation and treatment of any infection that may have started in the area since the debridement. Depending on the extent of the heloma removal by the carbon dioxide an application of silver nitrate may be applied at the discretion of the clinician. The patient is to return in one week.

The resulting eschar, if any, is removed at this visit. The progress of healing is noted. When the ulcer is healed to a sufficient degree, a dynamic latex shield is made to protect the area from the original etiology.

Return visits are made as the ulcer heals. Any alterations needed in the latex jacket are made. Once the ulcer is healed and the tissue is normal the patient need only return occasionally for a check of the area or the fabrication of a permanent latex shield.

Summary

At the present time the application of cryotherapy for the rapid removal of heloma durum has proven successful. The removal of the heloma is only one-half the treatment. The main objective is to prevent the return of the heloma. The treatment outlined here has proven effective to date. All the men who were under treatment maintained their normal duty status which was that of a full field duty soldier.

417 Fremont

® Pfizer and Co.

CURETTING VERRUCAE WITH MINIMUM HEMORRHAGE

VIRGIL C. OVERCAST, D.S.C.
Missoula, Mont.

Verrucae are benign, highly vascular neoplasms, consisting of much connective tissue as well as epidermis. They occur on hands, feet, face and other parts of the body. We are concerned here with the verrucae arrida that occur on the feet.

There are many successful methods of removing verrucae. As a general rule curetting is low on the list of methods of choice. In this office it is first choice, the preferred method. The reason for this is the high percentage of success we have had with this one method of treatment and because very little, if any, scarring occurs.

The disadvantages to this treatment, as it has been practiced in the past, are hemorrhage, adhering of the gauze on first re-dressing, and bulky first dressing necessary to minimize bleeding when no sutures are used. These disadvantages have been overcome by the use of a Gelfoam®[1] sponge.

Here is our suggested method, using the Gelfoam, which makes curetting our preferred method.

Aseptic technique is used throughout the operation. The tissue is anesthetized by local infiltration or regional block. The outline of the verruca is incised perpendicularly with a narrow scalpel. Blunt dissection is used to curette the verruca. This leaves a ragged overhang which is cut back until the margin is smooth and clean. (I use sharp scissors and scalpel to do this.) Trim clean the rough base of the cavity with a scalpel.

®[1] Upjohn

Cut a piece of Gelfoam the same size as the wound. Place Gelfoam in the wound, and apply slight pressure. Bandage with several 2″x2″ of sterile gauze. Rest and elevation are required the first day.

On the second day, re-dress with care to prevent hemorrhage. The use of Gelfoam makes the first re-dressing much easier. The gauze does not adhere and the Gelfoam can be left in the wound where it will provide a framework for granulation tissue and will resolve in a few days. The first re-dressing consists of an antiseptic healing ointment and a light gauze bandage. Instructions are given the patient to resume normal activity.

The second re-dressing should be one week after the first. An antiseptic healing ointment under a knuckle bandage is usually sufficient dressing. This should be worn for a few more days. If the wound is not completely healed by that time a Band-Aid®[2] is sufficient until it is.

Conclusion and Summary

1. A method of verruca curettage that is highly successful has been presented.

2. Gelfoam sponge controls post-operative hemorrhage by minimizing capillary oozing and bleeding. This makes suturing unnecessary, hence there is less scarring. The bandage is less bulky. Gelfoam aids in healing the wound since it provides a framework which granulation tissue may invade. It can be left in the wound. Usually within 2 to 5 days it will be completely absorbed.

3. At the first re-dressing, gauze does not adhere so the clot and/or Gelfoam is not disturbed. There is very little, if any, after pain. When proper precautions are followed the chances of infection and consequent slow healing are minimal.

203 Wilma Bldg.

®[2] Johnson and Johnson

SURGICAL REMOVAL OF A NEUROFIBROMA A CASE REPORT

MARVIN J. SOFFER, D.S.C.*
Gloucester, N. J.

A 30 year old white female presented herself at the office complaining of a lump on her left foot. She stated that "it has been getting slightly larger in the past couple of months."

Examination revealed a mass dorsally overlying the intermediate and proximal phalanges and web of the third toe. On palpation, the mass was found to be subcutaneous, and non-adherent to the extensor tendon. Excision was advised and the patient consented to surgery.

The following day the patient was admitted to the hospital. A complete physical and history by the medical department was done, and laboratory and x-ray studies were made on admittance.

At 7:00 a.m., on the day of surgery, the patient was premedicated with sod. seconal gr. iss, and Demerol Hcl®[1] 50mg. At 8:00 a.m., surgery was performed under local anesthesia with 5 cc's of Cyclaine Hcl®[2], 1%, plain.

The skin and subcutaneous tissues were incised over the mass, care being taken not to incise the neoplasm. The tissues were retracted and the mass was exposed and delivered into the incision. The neoplasm was excised, by sharp and blunt dissection, from its attachment, in toto. One small persistent bleeder was tied off with 4-0 plain gut. The incision was approximated and closed with four interrupted sutures of 3-0 black silk.

A Telfa®[3] strip and sterile Kling®[4] compression bandage was then applied to the wound. Aspirin gr. X and codeine

*Staff Foot Surgeon, Audubon Hospital, Audubon, N. J.
®[1] Winthrop Laboratories
®[2] Merck, Sharp & Dohme Co.
®[3] Bauer & Black Co.
®[4] Johnson & Johnson Co.

sulfate gr. ss q. 4. h. was ordered for postoperative pain. The second postoperative day the patient was sent home, instructed to stay off of her foot as much as possible, and to return to the office in eight days.

Pathologist's Report

The specimen submitted consists of a well encapsulated grey mass, measuring 14 mm in diameter. On section, this is soft in consistency and grey in color.

Sections of the tissues submitted disclose the presence of fibrous connective tissue elements, the nuclei of which present the typical palisading effect of the neurofibroma.

There is no evidence of malignancy in the tissue submitted.

Pathological Diagnosis-Benign Neurofibroma.

On the tenth postoperative day, the sutures were removed at the office. Healing took place uneventfully. Six months postoperatively the patient was examined and no evidence of any pathology existed. The line of incision was just faintly visible, and was not elevated.

103 No. Broadway

OMISSION

Due to a mechanical error, the following was omitted from the article "An Evaluation of the Curettage Treatment of Plantar Verrucae," Vol. 47, No. 2, p. 68, by Bernard S. Weinstock, D.S.C. The following final paragraph was inadvertently omitted from the published version:

"The author wishes to acknowledge the consultation, guidance, and assistance he has had with and from Dr. Irwin Rifkin, Bronx, New York, formerly, Chiropodist, Dispensary No. 1, Brooke Army Medical Center, Fort Sam Houston, Texas."

The following reference was also omitted:

7. Hertz, Carl; cited in Modern Foot Therapy, page 240, Modern Foot Therapy Publishing Co., New York, 1948.

JOURNAL

OF THE

NATIONAL ASSOCIATION of CHIROPODISTS

PUBLISHED UNDER THE DIRECTION OF THE EXECUTIVE COUNCIL BY THE NATIONAL ASSOCIATION OF CHIROPODISTS

3301 SIXTEENTH STREET, N.W., WASHINGTON 10, D. C.

A. RUBIN, D.S.C., *Editor*

FRANKLIN R. FIELDING, B.S., B.S.A., M.F., *Business Manager*

Address all communications intended for publication, matter relating to advertising, business or subscriptions to the above address.

PRESIDENT'S MESSAGE

Why Belong?

You need the National Association of Chiropodists and we need you. The support that is gained by your membership is a most valuable asset. The concentrated efforts that are being made to advance the profession of chiropody deserve the assistance of every chiropodist. During the past ten years there has been widespread recognition achieved through the development of the Stickel Ten Year Plan. You should be proud of these brief facts:

Our valuable Headquarters Building in Washington is now completely amortized.

Chiropodists are now commissioned in the Medical Service Corps of the Army, Navy, and Air Force.

The Department of Health, Education, and Welfare has given chiropody complete professional standing.

The U. S. Public Health Service is revising its foot health information with our consultation.

The Dictionary of Occupational Titles (U. S. Office of Education Vocational Guidance) now presents the modern definition of our profession.

Inter-professional Councils include our profession in many states.

The shoe industry has sought our scientific facilities for research and has made grants available.

The National Formulary now includes a section on chiropodical drugs.

The new edition of the Standard Nomenclature of Diseases and Operations, now in preparation, is giving consideration to chiropody terminology.

Chiropody service is included in more private and group insurance contracts than ever before.

The Journal of the National Association of Chiropodists is the finest periodical concerning foot welfare published today.

A Statement of The Policies of the N. A. C. has been issued that defines our practice and clearly indicates that the objectives of our profession are predicated on improving the foot welfare of the public.

We are now enterinng a new dynamic phase of development with a Five-

Year Plan to be projected. You will want to be a part of every minute of this exciting future of your chosen profession.

There is little a non-member can do to cope with the advancement projects that are requisite for the growing profession of chiropody. Legislation, public relations, school children foot examinations, industrial foot surveys, and the attainment of privileges of all kinds require group action by the recognized National Association of Chiropodists and State Society. An individual chiropodist would be staggered by the costs involved in providing basic services that are rendered in his interest by the staff of the N. A. C.: Secretary and Editor, Business Administrator, Medical Consultant, Legal Counsel, Accountant, and Office Staff. The average chiropodist would not be willing to give the long hours of time to the voluntary duties performed by members of N. A. C. Committees, Council on Education, Executive Council, or Officers of the Association.

WHY BELONG to the State and National Association of Chiropodists? You enjoy the benefits they are producing. Do your part by giving support through membership.

This year the N. A. C. extends an invitation to every eligible chiropodist in the United States to become a participant in the Association. Dr. William S. King of Tennessee, Chairman of the N. A. C. Membership Committee, along with Sectional Assistants, Dr. Russell Bliss of California, Dr. E. C. Barron of Arkansas, and Executive Councilman, Harry Horowitz of New York, has designed an extensive campaign to place in the hands of every chiropodist the privilege of membership as explained in the inserted pages at the back of this N. A. C. Journal. Many states are going to sponsor friendly calls on every chiropodist in their state to inform them of the progressive attitudes of the N. A. C. and their state society. The JOURNAL will be sent to non-members in other states. Do not wait for someone to ask you to join, step ahead and sign an application now.

Without a doubt some individuals have problems concerning membership So do I, and I have tried to think of some of the general problems and some possible solutions. Here they are:

P. Eligible but neglected to pay dues on time and was notified of lapse in membership.
S. We miss you—mail a check now for reinstatement—it's that easy.
P. Could not afford high dues. Just starting in practice.
S. Better put away a treatment fee a week for dues—you'll have enough left over to attend conventions.
P. Have been a member for years, slowing down, just quit.
S. A sure way to grow old fast. We young ones need your advice.
P. Get tired of long-winded debate at meetings, quit.
S. So do I but someone generally turns up with a good idea.
P. A clique runs everything.
S. Thank goodness someone runs things—maybe your turn is next.
P. The Association does nothing for me.
S. Read all about it in this Journal.
P. I have to advertise to stay in practice.
S. Stop kidding yourself. It costs to advertise and only your hands pay

for it. Comprehensive treatment is worth more to a patient but patients with comprehensive minds do not seek an advertiser.

P. Had a dispute with a member and quit.

S. You are missing the friendship of the fellows you like because of an incident. It isn't worth it.

P. Can't take some of the personalities.

S. Do not let personalities interfere with your personal progress.

P. No time for conventions, have other interests.

S. Better open your eyes real wide and see that new techniques and office practice methods are needed to keep patients in your office. Conventions pay off. You can keep your other interests too.

Felton O. Gamble, D. S. C., *President*

FIFTY YEARS OF INFORMATION

As WELL AS being a "membership" issue this issue of the *Journal of the National Association of Chiropodists* marks the 50th year of publication of our Journal and its predecessor.

In 1907 only the State of New York had a law regulating the practice of the profession protecting the public from unqualified practitioners. Today, and for almost twenty years, all the 48 states and the District of Columbia have such laws.

In 1907 Societies of members of our profession existed only in the States of New York, New Jersey, Illinois and Massachusetts. Today the National Association of Chiropodists has 49 affiliated chapter societies and the *Journal* has subscribers in all the major Western European, North and South American, and Australasian countries.

The growth of the *Journal,* from several hundred to today's 6,200 copies published monthly, reflects the growth of the profession and the utilization by the public of the service rendered by our members.

We provide a service for foot health and care without taking our patients off their feet. Our techniques enabling us to keep a patient ambulant have, in addition, profound economic, psychologic and sociologic implications.

The *Journal* feels very proud to have had a major part in the dissemination of this technical knowledge to all segments of our profession and other interested professions.

We have just learned that Dr. D. L. Caviness of Chico, California, whose death was reported in our February issue, is very much alive. We regret the error.

Congress Considers

Tax exemption or deferment is certain to be a popular subject for Congressmen and constituents alike, to endeavor to attain. In the two previous Congresses, Representatives Jenkins (Ohio) and Keogh (N. Y.) have advocated appropriate amendments to the tax law, but with indifferent success because of opposition presented by the Federal Tax Bureau. The bills were stimulated by the enactment of the Old Age Social Insurance Act which permitted the taxpayer to deposit in a special fund a certain percentage of a stated amount of income to become available upon retirement at age 65. There was objection to the creation of this special fund and the objectors drafted a bill which has become the Jenkins-Keogh Bill. Congressmen looked askance at the new proposition, seeming to consider the intention more of an effort to evade taxes than to set up a retirement program. But lately interest in the proposal seems to be growing, and accordingly the Congressmen have reintroduced their bills in the new congress, namely H.R.9 Jenkins and H.R.10 Keogh. Their bills are identical and were drafted by the American Bar Association. The purpose of the bill is to encourage the establishment of voluntary pension plans by self-employed individuals.

The bill would permit only self employed individual taxpayers to deduct from adjusted gross income a limited amount equal to payments made by him each year to obtain retirement income for himself or payments to his beneficiaries or his estate. Annual payments, referred to as "retirement deposits" would be limited to no more than 10% of net earnings from self employment or $5000 annually, whichever is lesser. The total deductions allowed could not exceed $100,000 during the taxpayer's lifetime. For persons between ages 50 and 70, an additional 10% could be added for each year of age over age 50.

Persons who are both self-employed and at the same time holding a job as an employee and making payments into employee trusts, together with persons covered under government pension plans, cannot be eligible for tax benefits under this proposal. Retirement deposits to be deductible must be paid into a retirement fund operated by a bank or into a life insurance company plan providing for an annuity, endowment or life insurance contract but not for term life insurance. Provision is made for reporting to the Bureau of Internal Revenue by banks and insurance companies so that the tax authorities would be on notice that a taxpayer is exercising the tax deduction privilege.

The bill provides for a right to take down or surrender for cash prior to age 65 by the taxpayer or earlier, and the privilege of borrowing against deposited funds under certain conditions if he becomes permanently and totally disabled prior to that age.

Ten other members and one Senator are sponsoring bills which are identical or have minor variations, for example, Representative Coudert of New York would permit the deductions to be made from "gross" income of amounts equal to premiums paid during the taxable year on any annuity or life insurance contract upon the life of the taxpayer. However, such payments must not exceed 10% of the "adjusted gross income." Senator Dirksen of Illinois sponsors a similar bill in which he differs by allowing a deduction of 10% of earned income or $7,500 annually, whichever is lesser, but not to exceed $150,000 in a lifetime.

Another series of bills in both Houses would permit deductions from income tax,

amounts paid as tuition or fees to certain public and private institutions of higher education. Representative Thompson of New Jersey sponsors a bill, H.R.490, that would provide a 30% credit against the individual income tax due in any taxable year to be paid during the year to institutions of higher education as tuition fees, either for himself or for another. Such schools or institutions must be recognized as offering education at a level above the twelfth grade. Representative Boggs, Louisiana, sponsors H.R.1064, an identical bill. Representative McCarthy of Minnesota sponsors a similar bill, H.R.765, except that he limits the tax credit to not more than $450 per taxable year. Representative Zelenko sponsors an identical bill H.R. 1036. Senator Fulbright, Arkansas, S.432, would allow an additional exemption of $600 for the taxpayer for his spouse, or for a dependent child, provided they are attending an educational institution above the secondary level during at least four months in any calendar year. Representative Multer, New York, sponsors a similar bill, H.R.808, in the other House.

Senator Fulbright has another bill S.433 which is similar to the preceding. It would permit a taxpayer who is a student to deduct amount paid by him to such institution for tuition fees and necessary books and supplies. Representative Trimble, Arkansas, sponsors an identical bill H.R.3113, and also a bill H.R.3114, identical with Senator Fulbright's bill S.432. Senator Humphrey, Minnesota, is sponsoring a similar bill which would allow a taxpayer to subtract from income tax due in any taxable year an amount equal to 30% of sums paid during the year to institutions of higher education as tuition or fees either for himself or another but not to exceed $450 in any one year. Senator Langer of North Dakota sponsors a bill S.175 that permits an additional exemption of $600 for each dependent child who is a full-time student at college.

Representative Anfuso, New York, sponsors a bill, H.R.3601, which provides tax exemptions in computing personal income tax and provides for a deduction from adjusted gross income expenses for the college education of his children. The maximum deductible expenses may not exceed $1,000 in any tax year.

All of these bills have been referred for study and decision in the Senate to the Finance Committee and in the House to Ways and Means Committee.

The personnel of those committees is:

Senate Committee on Finance

Messrs. Byrd (Chairman), Kerr, Frear, Long, Smathers, Anderson, Douglas, Gore, Martin of Pennsylvania, Williams, Flanders, Malone, Carlson, Bennett and Jenner.

House Committee on Ways and Means

Messrs. Cooper (Chairman), Mills, Gregory, Forand, Eberharter, King, O'Brien, Boggs, Keogh, Harrison, Karsten, Herlong, McCarthy, Ikard, Machrowicz, Reed, Jenkins, Simpson, Kean, Mason, Holmes, Byrnes, Sadlak, Baker and Curtis.

To be happy in one's work, one must be fit for it, must not do too much of it, and must feel a sense of success in it.

Ruskin

SAVINGS THROUGH N.A.C. INSURANCE PLANS

THE following is a brief comparison of the N.A.C. Accident and Sickness plan, and the Professional Liability plan with individually-purchased, high quality, non-cancellable policies and individual Malpractice policies. This data show some of the economic advantages obtained through membership in the National Association of Chiropodists.

The N.A.C. Basic plan of 2 years' sickness, 5 years' accident monthly disability income, with the companion Extended Coverage policy provides benefits for a total of 7 years' sickness, and lifetime for accidental injury. In addition, it includes a cash payment of up to $14,000 for Dismemberment—i.e., the loss of hands, legs, sight, hearing, etc., and for accidental death.

Once a member is insured, his policy cannot be discontinued by the company prior to age 70, unless he retires or voluntarily ceases to be actively engaged in full-time duties of the profession, ceases to be a member of the N.A.C., or unless the Master Plan with the National Association is terminated.

As a rule, no medical examination is required. Members up to 69 are eligible for the Basic plan, and the maximum amount issued is $400 monthly income.

A comparable high quality, individual non-cancellable, guaranteed renewable disability income policy is issued by a number of reputable companies. These generally provide coverage for periods up to 5 to 10 years for sickness disability, and for lifetime accident disability.

Usually, these policies are issued to applicants up to 55, and coverage ceases at 65. Medical examination is always required. Generally, $300 is the maximum amount available.

At age 45, for $200 monthly disability income benefit, the premiums are approximately as follows:

N.A.C. (Including Extended Coverage)

$100.00 annually until age 51,
then 109.00 " " " 61,
then 142.00 " " " 70,
(includes $12,000 accidental death benefit)

Individual Non-Cancellable (Typical Policy)

$236.52 annually until age 65
(includes $10,000 accidental death benefit)

The premium for individual policies at younger ages is somewhat lower, and at older ages is considerably higher, and premiums in different companies vary slightly. The example cited is representative, and shows the savings effected through membership in the N.A.C.

Due to the current high cost of living, we recommend that members should, if possible, subscribe to both types.

Similarly, for Chripodists Liability (Malpractice) insurance, the following comparison between the N.A.C. Plan and the Standard Rates for individual policies shows substantial yearly savings:

Limits	N.A.C. Annual Rate	Individual Annual Rate
$ 5,000/15,000	$21.00	$35.00
10,000/30,000	27.30	47.25
15,000/45,000	29.61	54.25
20,000/60,000	31.29	57.40
25,000/75,000	32.13	59.85
50,000/100,000	34.23	66.15**
100,000/300,000	43.05	72.10

** Standard rate for $50,000/150,000.

The N.A.C. Insurance Plans Are Underwritten by:

Basic Accident and Sickness plan—The United States Life Ins. Co., New York, N. Y.

Extended Coverage—Bankers Security Life Ins. Society, New York, N. Y.

Chiropodists Liability—American Motorists Ins. Co., Chicago, Illinois.

Dr. Irving Pashin, Chairman,
Committee on Insurance

TECHNIQUES IN FOOT SURGERY

L. R. McCAIN, D.S.C., F.A.C.F.S., and N. H. KETAI, D.S.C., F.A.C.F.S.
Editors, Publications Committee, A.C.F.S.

Illustrated case reports and discussions, suggesting approaches to chiropodical surgery, from the files of the American College of Foot Surgeons.

A Surgical Approach for Heloma Molle

A white woman, aged 35, seen in the office, presented a heloma molle in the web between the fourth and fifth toes of the right foot.

Palliative treatment had been used for a period of several years, but the pain always returned, and in the past several weeks the heloma had become acutely painful. Radiograph findings indicated the base of the fourth proximal phalanx was nearly opposite the head of the proximal phalanx of the fifth toe.

Procedure: Anesthesia to the area was effected by use of Novocaine®[1] 2% with Suprarenin 1:20,000. A tilted heart-shaped section of skin with about one-fourth inch extra skin on all sides of the hornified area was removed from between the fourth and fifth toes of the right foot. The bursa beneath the heloma was removed with blunt dissection. The wound was closed with interrupted and Halsted sutures.

Postoperative treatment was as follows: Three days postoperatively the area was painted with tincture of Merthiolate®[2] and rebandaged with sterile dressing. On the fifth day after surgery three of the five sutures were removed, and the wound re-dressed after application of tincture of Merthiolate. On the eighth day the last two sutures were removed and a sterile dressing applied. On the eleventh post-operative day the area was re-dressed with gauze between the toes, and strips of tape around the fourth and fifth toes. On the fourteenth day the patient was discharged and told to wear a loose shoe for a period of time.

G. H. Long, D.S.C.

Comment: This procedure produces a dactylosymphysis of the fourth and fifth toes. This, of course, makes it impossible for a heloma to form.

Since the surgery is done between the toes healing time is extended as is usual in these cases.

From a cosmetic standpoint the syndactylism may not be a desired consequence of the surgery, although this is only a partial syndactyliasis.

®[1] Winthrop-Stearns ®[2] Lilly

A Surgical Approach to the Heloma Molle

A white woman, aged forty-five, seen in the office presented very painful helomata molle between the fourth and fifth toes bilaterally. Conventional palliative treatment had proved ineffective.

Examination revealed blood pressure 130/90; radial pulse 72, oral temperature, 99°. A study of her serological, roentgenological and clinical findings were all within normal limits. Erythrocytes – 4,200,000; leucocytes–7,350; hemoglobin–12.8 grams per 100 cc. of blood; bleeding time 1½ minutes, coagulation time 4 minutes. Radiographic findings show hypertrophy of the fifth proximal phalangeal heads with a hypertrophy of the lateral side of the base of the fourth proximal phalanx, and an

atrophy of the shaft of the proximal phalanx of the fourth toe.

Procedure: The operative technique followed was essentially the same for both procedures except where otherwise stipulated.

Anesthesia to the area was effected by use of Xylocaine 2%®[3]. A skin-deep incision was made on the dorsolateral aspect of the fifth toe, extending from the base of the proximal phalanx to the head of the middle phalanx. This was deepened to the dorsum of the paratendon sheath of Extensor Digitorum Longus. This was followed by blunt dissection to obtain proper exposure of the articulation. The soft tissues were then retracted, and a transverse incision was made through the expansion of Extensor Digitorum Longus and the collateral ligaments. These newly severed tissues were sharply dissected back to permit exposure and dorsal delivery of the proximal phalangeal head. The head of the proximal phalanx was then amputated at the junction of the head and shaft, and with bone rongeurs the end of the shaft was rasped smooth. The wound was flushed with aqua pro injectione, sponged dry and closed with one vertical mattress suture placed in the center and three single interrupted sutures of 000 silk.

After depositing one cc. of Xylocaine 2% in the manner of a toe block just behind the head of the fourth metatarsal a second incision was made which extended from the most proximal part of the fourth metatarsal head to the head of the proximal phalanx along the dorsolateral aspect. The tissues were retracted and a lineal incision made in the capsule of the metatarsophalangeal articulation. These structures were carefully clamped with allis forceps and sharply dissected, exposing the enlarged lateral side of the base of the fourth proximal phalanx. This was then removed with mallet and osteotome, and rasped smooth. Closure was made by three vertical mattress and two single interrupted sutures.

The surgical procedure that was performed on the left foot was a resection of the head of the proximal phalanx of the fifth toe. Closure of the wound was maintained by one vertical mattress and three single interrupted sutures.

Postoperative treatment was as follows: The day following the surgery the pressure dressing was removed. Three days postoperatively the entire dressing was removed and the wounds were re-dressed with sterile dressing. They appeared slightly edematous which is a normal state for this stage. Seven days following surgery the wounds were again re-dressed, and the sutures removed. The patient was instructed to leave the dressings on for three days, after which they could be removed and bathed in clean soapy water. Thirteen days postoperatively there was a debridement of the cicatrix, and the wound was found healed.

One month after surgery the toes were in a normal attitude and asymptomatic. Three months after surgery there was no evidence of heloma molle.

Comment: The removal of the lateral side of the base of the fourth proximal phalanx, and the resection of the head of the proximal phalanx of the fifth toe, is the accepted procedure for the alleviation of heloma molle in the webbing between the fourth and fifth toe.

The procedure used on the left foot wherein only a resection of the head of the proximal phalanx was removed, or the technic wherein only the lateral side of the base of the proximal phalanx of the fourth toe is removed, is not considered as good technic. It can be seen that with either of these procedures being used, there is a chance for minimal pressure to be exerted, and over an extended period of time there may be a return of the heloma molle.

L. R. M. and N. H. K.

®[3] Astra

THE PODOPEDIATRIC CLINIC

JOHN T. SHARP, D.S.C.
Chairman, Committee on Children's Foot Health

This section is devoted to a discussion of the problems peculiar to the child's foot. A separate subject will be considered each month, on a question and answer basis. Members are invited to send in their questions relative to the various phases of podopediatrics. Questions will be answered in accordance with the heading under which they fall.

LIMP IN THE CHILD PATIENT

What is a "limp"?

Limp may be defined as any disturbance in the normal gait rhythm.

What are the causes of limp in the child?

Since any factor which produces an aberration from the time symmetry of weightbearing and progression in the extremities will give rise to limp, the causes are numerous. In general, limp may be divided into two main categories: 1. Antalgic Limp and 2. Neuro-structural Limp. In some instances forms which are combinations of these two groups may also be observed.

What is "antalgic limp"?

The term "antalgic" is derived from two Greek words: "anti"—against, and "algos" —pain. Consequently, an antalgic limp is one which is used to combat or relieve pain. Since pain in the extremities may arise from a multitude of causes, it may be seen that the etiology of this form of limp is quite varied.

What is "neuro-structural" limp?

The term "neuro-structural" is a combined form which embraces those varieties of limp which are secondary to either neurological disease or some structural fault in the ambulatory mechanism.

What are some of the causes of "antalgic limp"?

Since anything which produces pain in the extremities may give rise to this limp form, the etiology is myriad. Some of the more common causes are: painful pes valgoplanus, avascular necrosis (in any of the bones concerned with weightbearing and propulsion), sprains, muscle strains, fractures, neoplasms, chronic strain of the internal collateral ligament of the knee, and transient synovitis of the hip.

What are some of the causes of the "neuro-structural" form of limp?

From a neurological standpoint: Charcot-Marie-Tooth Peroneal Atrophy, Acute Poliomyelitis, Cerebral Palsy and Spina Bifida. From the structural standpoint: unilateral dysplasia of the hip, epiphysiolysis, coxa vara, unilateral disturbances of the epiphyses, and fractures.

What is "transient synovitis of the hip"?

This is an acute, non-specific inflammatory disorder involving the synovium of the hip joint. Suggested etiological factors are trauma, infection and allergy. It is seen more commonly in boys than in girls and the usual age incidence is between three and ten years. There is usually a sudden appearance of limp, and pain, either in the hip or knee. Motion in the hip is restricted, especially as regards abduction and external rotation. There is usually a hip flexion contracture present. X-rays are of value chiefly from a soft tissue standpoint, the only helpful finding being a swelling of joint capsule. It is well to remember that hip conditions often present referred pain to the knee. For this reason, any case wherein there is a complaint of knee pain should be examined very carefully for hip pathology.

What is Charcot-Marie-Tooth Peroneal Atrophy?

This is a neurological disease with strong hereditary tendencies. It involves chiefly the peripheral nerves and sections of the spinal cord. Early there is weakness in the distal parts of the lower extremities, especially in the peroneal group. This involvement is symmetrical. The patient experiences difficulty in walking and presents a drop foot type of gait. Talipes equinovarus usually develops, and the patient has difficulty in flexing the foot on the leg because of the muscular weakness present. The atrophy and weakness which begins in the lower leg gradually advance upward to the lower thigh. This results in the so-called "stork leg" or "rooster leg" appearance which is typical of the condition. There is an absence of the achilles reflexes, and sensory disturbances are common. The condition eventually involves the hands and arms as well as the lower extremity.

What is "epiphysiolysis"?

This is a condition occurring in the capital femoral epiphysis, which is characterized by a downward displacement of this epiphysis on the neck of the bone. It is seen usually between the ages of 8 and 19 years and is more common in boys than in girls. These patients are almost always of the obese type. They present a limp, with the extremity usually externally rotated. On measurement of the extremities, the involved side is shorter than the contralateral extremity. There is pain present which is often referred to the knee. Limitation of internal rotation and abduction of the hip is usually observed. The X-ray findings vary with the stage at which the films are taken. Early there is widening and irregularity of the capital epiphysis. Later there is a downward displacement of the epiphysis upon the neck, and the neck appears short and broad.

What is Coxa Vara?

This condition is one in which the normal angle between the shaft and neck of the femur is decreased. Usually this angle is about 125 degrees, although it is often less than this in females and greater in young children. It may be either congenital or acquired, and is most often bilateral. Acquired cases may be secondary to rickets, osteomalacia, fractures of the femoral neck, or epiphysiolysis. Bilateral cases present a waddling form of gait, while unilateral cases display a limp. Abduction and rotation of the thigh is restricted, and lumbar lordosis is frequently an associated finding. The X-ray reveals the deformity.

What is the chiropodical approach to cases which present limp?

Primarily of course the chiropodist must, in all instances where limp is a prominent symptom, determine the site of the pathology. This necessitates a thorough examination of both extremities. The motions of the foot, ankle, knee, and hip must be checked. The extremities must be scrutinized for variations in length, girth and positioning. The gait must be carefully analyzed, and the various reflexes tested. If pain is present the true origin of such pain must be ascertained. The patient is questioned relative to recent illnesses or injuries, since many cases of limp are secondary to such findings. Unless the extremity is examined in its entirety, many cases of limp will not be satisfactorily evaluated. It should be borne in mind that the fact that the parent brings a child to your office because she feels that the limp which is present is coming from a foot problem, does not necessarily indicate that the true pathology cannot be higher up in the extremity.

1424 Old York Rd.

PHARMACEUTICAL PREPARATIONS FOR THE PROFESSION

HARRY L. HOFFMAN, Ph.G., D.S.C.

Chairman, Council on Chiropodical Therapeutics and Pharmacy

A column devoted to preparations, new and old, with emphasis on their value and uses in everyday chiropody practice. This will be a regular monthly column and we invite questions, which we shall endeavor to answer, or obtain the answer.

Textrex Capsules
A Broad-spectrum antibiotic

Description: This is a new single antibiotic compound: (tetracycline phosphate complex). According to Bristol Laboratories, Tetrex provides doubly high antibiotic blood levels. We are told that within 1 to 3 hours after administration, Tetrex provides faster, higher and more efficient tetracycline blood levels, practically double those obtained from tetracycline hydrochloride. Higher levels are maintained for at least 24 hours. Bristol states that Tetrex is a single antibiotic, and offers all the obvious advantages of specific, uncomplicated, easily controlled, single-drug therapy, with an antibiotic of proven efficacy and safety.

While the basic antimicrobial spectrum of Tetrex is the same as that of tetracycline hydrochloride, it is a well-known fact that different strains of any one species of organism vary widely in their degree of sensitivity; and this is largely governed by the concentration of antibiotic at the point of infection.

Clinical indications for Tetrex include many infections due to tetracycline-sensitive organisms: Respiratory and urinary tract, gastrointestinal, dermatologic, rickettsial and certain viral infections; and for prophylaxis in surgery and obstetrics.

Dermatologic infections: cellulitis, furunculosis, pustular dermatoses, acne:

Dosage: 1 capsule 4 times a day. Severe or prolonged infections require higher doses. Children: average daily dosage 25 mg. per Kg. of body weight or approximately 12 mg. per pound of body weight. Doses should be divided and given at 6-hour intervals.

Therapy should be continued for 24 to 48 hours after the patient has become asymptomatic or afebrile. In acute streptococcal and staphylococcal infections, Tetrex therapy should be continued for at least 10 days.

Precaution: Use of antibiotics may occasionally result in overgrowth of nonsusceptible organisms. If superinfection does appear, antibotic therapy should be discontinued and supportive or specific therapy instituted.

Package information: Supplied in capsules containing Tetrex (tetracycline phosphate complex) equivalent to 250 mg. tetracycline HCL. Bottles of 16 and 100. By Bristol Laboratories Inc., Syracuse, N. Y.

Typical Prescription

Rx Capsules Tetrex aa 250 mg.
(Bristol)
Disp. # 16.
Sig: One Capsule 4 times a day.

Myanil
Antispasmodic, Analgesic

Description: Each tablet contains: Mephenesin . . . 250 mg., Salicylamide . . . 125 mg.

Action and Uses: Provides dual action formulated to relieve both spasm and pain. Useful in conditions such as: low back pain, bursitis, arthritis, and numerous neuromuscular dysfunctions.

Administration: Orally, 2 or 3 tablets 3

or 4 times daily, preferably at meal times. Dosage for children according to age and weight.

Supply: Myanil Tablets in bottles of 50, 100 and 1,000. By Reed & Carnrick, 155 Van Wagnen Ave., Jersey City 6, N. J.

Typical Prescription

Rx Myanil Tabs.
(Reed & Carnrick)
Disp. #L.
Sig. 2 tablets t.i.d. at meal time.

Tryptar Ointment

For all skin conditions attended with necrotic tissue.

Composition: Tryptar Ointment contains per gram: Trypsin (Crystalline) . . . 5,000 Armour units. Chymotrypsin (Crystalline) . . . 5,000 Armour units. Bacitracin U.S.P. . . . 500 units. Polymyxin B Sulphate U.S.P. . . 5,000 units In a specially prepared water-washable ointment base.

Caution: Federal law prohibits dispensing without prescription.

Action: The two natural proteolytic enzymes, tryspin and chymotrypsin, rapidly digest necrotic tissues for easy removal without adverse influence on living tissue and the healing process. Polymyxin is active against gram-negative bacteria and such resistant invaders as pseudomonas aeruginosa. Bacitracin acts against gram-positive pathogens, especially staphylococci.

Special Ointment Base: Smooth flowing—gently clinging—water-soluble for easy removal of digested debris.

Indications: Superficial skin lesions, indolent ulcers, thermal and chemical burns (2nd and 3rd degree), decubitis ulcers, and other lesions of the skin attended with necrotic tissue, secondary infection, hard eschar, or phagedenic membrane. Otitis externa (acute and chronic) responds rapidly.

Side Action: Antigenicity to trypsin and chymotrypsin has not been reported. Occasional transient slight itching immediately after application.

Administration: Apply once or twice daily. Lesion may then be covered with dry gauze. Usually 2 to 4 days of treatment will cleanse the wound and permit natural healing.

Supplied: In tubes of ½ ounce (15 gm.). By the Armour Laboratories, Division of Armour & Company, Kankakee, Ill.

Typical Prescription

Rx Tryptar Ointment 15 Gm.
(Armour)
Disp. Tube #1.
Sig: Apply twice daily. Cover with dry gauze.

Butisol Sodium "Intermediate" Sedative

Description: Butisol Sodium is 5-ethyl-5-secondary butyl barbiturate, McNeil.

Action: Butisol Sodium in average oral doses produces a mild sedative effect with an onset of action within 30 minutes and a duration of action of approximately 5 to 6 hours. The duration of action of Butisol Sodium is "intermediate" between the short-acting barbiturates, such as pentobarbital, and the long-acting drugs such as phenobarbital.

Indications: Butisol Sodium is useful in those conditions in which mild, relatively prolonged sedation is desired, as in essential hypertension, coronary artery disease, congestive heart failure; premenstrual tension and the menopausal syndrome; functional gastro-intestinal disorders (e.g. irritable colon, emotional diarrhea, peptic ulcer), anxiety neuroses and tensional states; hyperthyroidism; insomnia, and preoperative apprehension.

McNeil sights these advantages: 1. Mild sedation of "intermediate" duration without the hazard of accumulation or development of tolerance associated with the prolonged administration of phenobarbital. 2. Smooth sedative effect for daytime use without the peaks of excessive depression

produced by the short-acting barbiturates. 3. Destroyed in the body, probably by the liver. Butisol Sodium does not depend on excretion in the urine and therefore is not contraindicated in the presence of renal disease. 4. Metabolized at a rate which permits the administration of effective doses as needed, with little likelihood of accumulation, tolerance, or toxicity. 5. Remarkably free of undesirable side effects. Does not produce nasal stuffiness, depression, muscular aches and pains, or neurological distrubances, which are side effects sometimes produced by sedatives such as the rauwolfia preparations. 6. Available in a number of different dosage forms and strengths which are readily adaptable to the individual patient's needs. 7. Utilization of the new Butisol R-A (repeat action tablet) provides a sustained effect for 8 to 12 hours with a minimum of inconvenience.

Suggested Dosage: Elixir Butisol Sodium (colored green) contains 30 mg. (½ gr.) per 5 cc. (one teaspoonful). As a sedative, ½ to 1 teaspoonful (2.5 to 5 cc.) with water, three or four times daily. As a hypnotic, 3 teaspoonfuls (15 cc.). For children, the dose range is ¼ to 1 teaspoonful depending on age and degree of sedation desired. Peppermint flavor makes the Elixir palatable and makes this preparation adaptable to a wide range of prescription uses.

Tablets 15 mg. (¼ gr.) (scored, colored lavender). As a sedative, one to four tablets daily. For children, ½ to 2 tablets daily.

Tablets 30 mg. (½ gr.) (scored, colored green). As a sedative, one to three tablets daily.

Tablets 50 mg. (¾ gr.) (scored, colored orange). As a preoperative sedative or bedtime hypnotic, one to two tablets.

Tablets 100 mg. (1½ gr.) (scored, colored pink) and capsules 100 mg. (1½ gr.) (colored lavender). As a preoperative sedative or bedtime hypnotic, one tablet or capsule.

Typical Prescription

Rx Butisol Sodium aa 15 mg.
(McNeil)
Disp. #12
Sig: One tablet t.i.d.

Empiral

Description: Combined analgesic and sedative. Each tablet contains: ¼ gr. Phenobarbital; 2½ gr. Acetophenetidin; 3½ gr. Acetylsalicylic Acid.

Indications: Restlessness or anxiety associated with minor pain, tension headache, neuralgia, dysmenorrhea. Useful for pre-anesthetic and postoperative medication.

Administration: One or two tablets repeated as necessary.

How Available: In bottles of 100 and 1,000.

Typical Prescription

Rx Tablets Empiral
(B & W)
Disp. Tabs # 24.
Sig: Two tablets, repeat as necessary.

Borofax brand Ointment

Description: A soothing emollient borated ointment containing lanolin.

Indications: To soothe or prevent chapping, chafing, diaper rash, dry skin, and to aid healing of minor wounds and abrasions.

Administration: Applied directly to the affected area, or on a dressing.

How Available: In tubes of ¾ oz. and 1¾ oz. Jars of 1 lb.

Typical Prescription

Rx Ung Borofax 60.0
(B & W)
Disp. tube #1.
Sig: Apply directly to affected area or on a dressing.

ABSTRACTS FROM THE CHIROPODY LITERATURE

ROBERT SHOR, D.S.C.
LOS ANGELES, CALIF.
Chairman, Committee on Publications

Editors of Local, State and Regional Publications are requested to provide copies to the Chairman of the N.A.C. Committee on Publications who is preparing this section of the Journal.

CHIROPODY RECORD

The Professional's Professional Dress, Joseph Doller, Chiropody Record, 1-2; 9-10, (Jan.-Feb. 1956), Oak Park, Ill.

Doller relates that as direct representatives of a noteworthy profession, we must not only act the part but dress the part. The way we equip an office as well as the manner in which we dress is equally important, each being done in good taste with an eye for neatness. Let us not only attempt to please our public, our allied healing fields, but place a wholehearted effort into pleasing each other.

Foot and Ankle Sprains, George C. Custer, Chiropody Record, 3-4: 32-34, 51, (Mar.-Apr. 1956), Oak Park, Ill.

A presentation of diversity of opinions regarding ankle sprains. Custer discusses a general procedure used in chiropody practice during the past twenty years.

CONNECTICUT CHIROPODIST

Ultrasonic Wave in Chiropody, V. A. Jablon, Conn. Chiropodist 4: 3, 1955.

Description of this new form of modality for physiotherapy work in Chiropody, Jablon, in giving over 50 treatments with this modality, feels it is a necessary piece of equipment to have in the Chiropody office, in order to give the most that is available for our patient's comfort and relief.

Some of the reactions have appeared to be miraculous, and it is certain that time will register some of the unusual relief that can be afforded patients who may not have responded well to other forms of physiotherapy treatment.

Fibromatosis, D. C. Rasmussen, Conn. Chiropodist 4: 6, 1955.

Description of firm subcutaneous nodules in the ligamentous tissues of the plantar surface of the feet, Drs. R. A. Allen, L. B. Woolver and R. K. Ghormley of the Mayo Clinic at Rochester, Minn., report this condition, plantar fibromatosis, is at times associated with Peyronies disease, knuckle pads, kelois, and nodules in ligamentous tissue elsewhere in the body. It usually occurs in the fourth decade and is more prevalent in men than in women.

CURRENT CHIROPODY

Inferior Calcaneal Spur: Its Treatment with Ultrasound, Irving F. Jacobson, Current Chiropody, 15: 7-10, October 1956.

The treatment of six cases of inferior calcaneal spurs with ultrasound is presented. Ultrasonic therapy produces three main results: 1. It relieves pain. 2. It increases circulation. 3. It produces an absorption of excess deposits of calcium. Jacobson believes that ultasonic therapy is of definite value in the relief of pain due to calcaneal spurs.

FOOTPRINTS OF THE CHIROPODY ASSOCIATION OF FLORIDA

Sudeck's Atrophy, George Horn, Footprints of the Chiropody Assoc. of Florida, 4: 3-4, (Jan. 1957), Miami Beach, Fla.

Sudeck's Atrophy or Secondary Bone

Atrophy, too often gone unrecognized because of the apparent lack of information, has recently been receiving more adequate attention. The three forms or stages of Sudeck's Atrophy are described, namely, the acute, spotty bone atrophy, the chronic form of bone atrophy with unhealed focus, and the chronic traumatic distrophy of limbs following injury.

INDIANA STATE PODIATRY JOURNAL

Medical Treatment of Digital Deformities, Milton E. Ashur, Indiana State Podiatry Journal, 21: 4, (Jan. 1957).

Ashur discusses a number of ways in which our profession may treat painful disorders of digital deformities.

The relationship of muscle spasms to pain is overlooked because the spasm develops gradually. In this vein therapies such as Vitamin C, ointments to reduce skeletal muscle spasm, and the use of the mephenesin compounds are presented.

THE JOURNAL, CHIROPODY SOCIETY OF PENNSYLVANIA

Ultrasonic Therapy in Post Traumatic Ankle Fibrositis, V. A. Jablon, The Journal, Chiropody Society of Pennsylvania, 1: 8-9, February 1956.

Dr. Jablon presents a case report on traumatic ankle fibrositis as treated with ultrasonic therapy. The ailment, a stiff and painful ankle, is of two-year duration. Successful relief of pain is brought about in a few treatments. Jablon believes that this mode of therapy brought about a better physiological and functional foot for the patient.

JOURNAL OF PODIATRY

Perspective and Potential of Podiatry, Marvin D. Steinberg, Journal of Podiatry, 1: 10-13, (Jan. 1957), New York, N. Y.

Steinberg presents two case histories clarifying statements based on the following premise: Differential diagnosis is a prime requisite in the practice of Podiatry or in any medical or surgical specialty. Once a diagnosis is established, the proper course of therapy is self-evident.

Many conditions or lesions are brought within our scope of practice by virtue of recognizing them accurately. Many conditions outside our complete scope are recognized and properly directed for other specialty care.

If we are to be the specialists of the foot, then we must be adequately prepared, for the public, and no one else, will eventually decide who will care for the human foot.

JOURNAL OF THE WISCONSIN SOCIETY OF CHIROPODISTS

Calcaneal Spurs; Simplified Methods of Treatment, James R. Regan, M.D., Gleanings, Journal of the Wisconsin Society of Chiropodists, Milwaukee, Wis. (Reprinted in Rhode Island Chiropody Journal, 4: 10-11, (Jan. 1957).

Regan reports a simple and effective treament for calcaneal spurs based on work performed on the obliterative therapy in varicose veins and other related problems.

The technique of injection is fully described and the results on 33 patients discussed.

RHODE ISLAND CHIROPODY JOURNAL

The Sphygmo-oscillometer: A Diagnostic Aid in Peripheral Arterial Disease, Harry W. Weinerman, Rhode Island Chiropody Journal, 4: 6-7, (Jan. 1957), Providence, R. I.

Weinerman explains why Chiropodists-Podiatrists must be prepared to detect the existence of any disturbance in the physiology of peripheral circulation since their practice is confined to the lower extremities. The sphygmo-oscillometer is a reliable means of disclosing impair in arterial circulation. In this light, the principle of the oscillometer is discussed.

DIGESTS FROM THE LITERATURE

Anyone wishing to read the complete article, if not available in your local library, may borrow it through interlibrary loan. A microfilm may be borrowed from the National Medical Library, Washington 25, D. C., or a photo-duplication may be obtained from that library at a cost of fifty cents for five consecutive pages.

ANESTHETICS

Diphenhydramine Hydrochloride as a Local Anesthetic Agent, C. G. Steffen, M. Zimmerman and R. Mihan, Arch. Derm. 74: 76-79, 1956.

A clinical investigation of an antihistamine, diphenhydramine hydrochloride as a local anesthetic in minor surgical procedures on the skin proved unsatisfactory in 0.5 per cent concentration, but a 1 per cent concentration proved a satisfactory substitute for 2 per cent procaine in patients allergic to procaine or who obtained little anesthesia from that agent.

CIRCULATORY SYSTEM

Dietary and Drug Therapy of Edema, B. L. Martz. J. Indiana M. J. 49: 151-54, 1956.

If restriction of activity and digitalization fail to control edema, it is necessary to decide how best to combat excessive sodium and water retention associated with heart failure. Since a limited diet may cause approximately equal decrease in sodium and chlorine intake, no electrolyte imbalance may be produced. Substitution of salt-free bread and butter may be the only major alteration required in dietary habits. Use of special bread and butter, avoidance of salty foods and processed meats, can reduce sodium intake of 3 to 6 Gm. to a level of approximately 1 Gm. per day. In cases of severe sodium and water retention, further restriction of dietary sodium to 500 mg./day or less may be necessary. (Such a diet is outlined). If sodium diet cannot be restricted sufficiently to control edema, diuretic agents may be required. Mercurial agents are the most potent and are given intramuscularly and sometimes subcutaneously; intravenous administration is rarely indicated. Mercurial diuretics may cause a significant increase of potassium excretion, decrease of plasma chloride and increase of carbon dioxide content. Such patients must be given in addition a liberal supply of chloride ions (3 to 12 Gm. ammonium chloride per day for 3 to 4 days per week), and potassium (as orange juice, potassium chloride or potassium triplex.) Other agents recommended include Diamox, oral mercury, aminometramide, singly or in combination, in stated doses; Carbo-Resin, supplementary potassium before meals, and sodium removing resins. Application of elastic wrappings to the lower extremities and/or maintenance of the lower extremities in an elevated position for several hours following administration of a diuretic agent may help to prevent pulmonary edema.

Stripping of Varicose Veins with a Double Stripper, R. S. Greco and R. E. Flood. West Virginia M. J. 52: 167-68, 1956.

Minimal scarring for cosmetic reasons is desirable in surgical treatment of varicose veins. The accepted procedure is high ligation of the greater saphenous vein and its tributaries, with thorough stripping of the varicosities. It is important that the stripper pass the entire length of the vein. An Emerson srtipper is illustrated, which has a special coupling as a precautionary measure in case tearing of the vein occurs. If the vein has been completely removed

when the first stripper is removed at the ankle, the second stripper is easily pulled out. If tearing has occurred, the strippers are detached and stripping is repeated in reverse manner.

Use of Foam Rubber in the Compression Therapy of the Postphlebitic Leg, E. J. Orbach. Angiology 7: 152-55, 1956.

A new appliance is described for compression of the postphlebitic leg. It is composed of a purified foam rubber material vulcanized to an elastic cotton bandage as a backing. No skin allergy against rubber developed in a series of 30 patients. The bandages are easily applied. A 3-inch bandage is used to cover the foot, heel and ankle; a 4-inch bandage to cover the lower leg from ankle to knee. The bandage stays in place both in the region of the lower leg and in the region of the thigh. It is used without the aid of an adhesive compound.

Anatomo-Functional Phlebography, E. D. Diez and H. A. Ferrando. Angiology 7: 159-70, 1956.

Treatment of the varicose patient should not be attempted until exact knowledge is obtained of the functional condition of the deep venous system, so that the high percentage of relapses is avoided. In 98 per cent of cases the original thrombosis settles in the deep veins of the calf. The thrombosis occluding the venous lumen irritates the walls, causing an acute phlebitis and periphlebitis to develop. Phlebographic studies in one or both limbs were made in 1,053 patients with venous disease of the lower limbs (excluding thromboses). The contrast medium used was Diodrast. An anatomo-functional phlebography will indicate any pathologic deviation of the physiologic phenomena intervening in the return venous circulation of the lower limbs. Forces concerned in this return are (a) those that block the venous return; (b) those that help venous return and, (c) valvular action. Increase of venous pressure blocking return is controlled by use of Valsalva's maneuver. When the valves are sufficient, closing fractionates the column of blood, and a perfect image is obtained. If there is valvular failure, the retrograde flow is projected distally and shows in the radiogram as a fullness of the tibial and fibular venous trunks. Systematic use of this new method of diagnosis is suggested in patients with any type of phlebopathy; it should always be done on both limbs, since phlebography often shows pathologic conditions in different evolutive periods, requiring different treatments.

Progressive Bacterial Synergistic Gangrene: Report of a Case Treated with Chloramphenicol. Ann. Int. Med. 44: 1007-15, 1956.

A case is reported of progressive bacterial synergistic gangrene occurring in the right lower leg of a 32-year-old woman, following a slight trauma. The synergistic agents were found through animal inoculation studies to be micro-aerophilic nonhemolytic streptococcus and *Aerobacter aerogenes.* Only one other case was found in the literature wherein an organism other than hemolytic *M. aureus* had produced the disease in synergistic association with micro-aerophilic nonhemolytic streptococcus. Penicillin and streptomycin therapy was ineffective and was discontinued after four days; sulfisoxazole given for three days produced no response; compresses for six days and 1 per cent gentian violet in 10 per cent alcohol used locally were also ineffective. Cure followed administration of chloramphenicol 500 mg. four times a day (total dosage 66.5 gm. over a 35-day period), together with local measures, including ¼% silver nitrate and ½% chloramine-T-compresses to control secondary invaders.

An Evaluation of Peripheral Arteriosclerotic Insufficiency Utilizing Radioactive Iodinated Human Serum Albumin, E. J. Halligan, J. C. Gibbs, Jr., et al. Surg.,

Gynec. & Obst. 102: 511-16, 1956.

Repeated tracer doses of radioactive substances can be safely used to study peripheral circulation and to evaluate the effect of therapeutic measures on the status of the circulation. A study was made of the circulation of the lower extremities. Following injection into an antecubital vein of 40 microcuries of radioactive iodinated human serum albumin, 1 cc. in volume, counts per minute, as recorded by an Esterline Angus plus count rate meter apparatus, show a gradual increase up to a point where a plateau is reached. After establishment of equilibrium, the number of counts are determined for 1-minute periods, the counts being taken over the ankle, calf and thigh and compared with those taken over the region of the femoral artery near the inguinal ligament. This gives the ankle to femoral (A/F) ratio.

Following establishment of normals, it was found possible to increase the A/F ratio 20 to 30 per cent by the presence of cellulitis or induction of spinal anesthesia. Arteriosclerotic patients presented a higher A/F ratio than normals, due to stasis or pooling of blood in the extremity. This finding was considered secondary to (1) a diminished pressure gradient produced by encroachment of arteriosclerotic deposits and proliferated intima upon the lumen of major vessels; (2) lessened elasticity of larger vascular radicles through calcific infiltration and fibrosis; (3) increase of the collateral circulation; (4) tissue anoxia producing dilation of capillaries and veins, and an increase in permeability for liquid components of the blood, together with a tendency toward sludging of the other elements of the blood. In a normal individual the capillaries, arterioles and venular bed of skin, muscle and bone comprise a reserve or collateral bed. This reserve is gradually consumed in a patient with arteriosclerosis obliterans, to compensate for obliterative changes in the arteries and large arterioles. in the advanced state the reserve is depleted and the major vessels occluded; the patient shows marked muscle atrophy, dry skin, ridged and hooked nails, lack of hair on the legs and gangrenous digits. Both total blood volume of the leg and blood flow are reduced, as demonstrated by decrease in A/F ratio to below normal levels and decrease in circulation index.

Therapy to be administered is determined according to the status of reserve or collateral. Apparently hopeless cases, requiring amputation, by use of this isotopic technique may show the circulation better than suspected and amenable to conservative methods. This procedure was used to determine the effect of various drugs and operative procedures. In patients with moderate disease, lumbar sympathectomy may bring clinical improvement, but its use should be limited to patients with moderate disease, embolism, and vasospastic conditions. No improvement is noted in those with advanced disease.

DERMATOLOGY: ALLERGY & FUNGUS DISEASES

Chronic Neurodermatitis: A Clinical Study, N. Tobias. Missouri Med. 53: 374-76, 1956.

Circumscribed neurodermatitis (lichen simplex chronicus) requires treatment as a neurosis more than as a skin disease. In the 125 cases studied, 80 patients were female and 45 male. The affected areas in the female were nape of the neck, anogenital areas, inner thigh, ankles, eyelids, and especially the ears. In the male the areas were thigh, arm, leg, scrotum, anus. Most of the patients were in the fourth decade. Minimal itching may be controlled, but a chronic itch-scratch is pathologic. The disorder may be due to anxiety, worry, envy, hatred or fatigue. Four cases are discussed and various treatments are suggested.

Tinea Pedis and Relapsing Erysipelas, P. Dostrovsky and F. Raubitschek. Harefuah 50: 31-33, 1956.

An English summary to this Russian article states that clinical exidence of tinea pedis was found in all of the 55 cases reported herein. In 38 fungi were seen microscopically, and on culture in 10 of these. In three hospitalized cases hemolytic streptococci were isolated from the erysipelatous area. The method of isolating the streptococci is described. No fungi were found in histologic sections from the erysipelatous region. In the cases of erysipelas recidivans of the lower extremity it is postulated that the cause was the hemolytic streptococci which gained entry to the lmyph spaces through fissures due to tinea pedis.

Antibiotic Treatment of Bacterial Infections of the Skin, L. Katzenstein. Delaware M. J. 28: 113-14, 116, 1956.

Bacitracin and neomycin in ointment form present the most advantages and fewest disadvantages in treatment of bacterial infections of the skin. Oral penicillin is the drug of choice when systemic antibiotic therapy seems indicated; when ineffective, the broad-spectrum antibiotic may be used, if administration is not too prolonged. Penicillin and sulfonamide ointments are contraindicated except in infants and young children. Local use of an antibiotic may sensitize a patient and when systemic use is required later, a drug reaction may occur.

Clinical Evaluation of Topical Fludrocortisone, J. van de Erve, Jr. Arch. Derm. 74: 92-94, 1956.

A clinical study is reported of 335 cases of dermatitis treated with hydrocortisone and fludrocortisone applied locally in lotion and ointment form, thrice daily, for a period of 14 to 21 days. The fludrocortisone was used 1/10 as strong as the hydrocortisone but proved equally efficient. They were most effective in dry erythematous forms of dermatitis. In acute vesicular weeping dermatoses, use of the standard treatment, wet dressings and lotions or ointments, produced the dry erythematosquamous stage and the cortisone preparations afforded some relief. Infectious eczematoid dermatitis and other dermatoses with a primary or secondary pyogenic component did not do well on topical therapy. No sensitization to the drugs occurred.

Evaluation of an Iodonium Compound as an Antiseptic Agent, W. E. Englehard and A. G. Worton. J. Am. Pharm. Assoc. 45: 402-04, 1956.

Investigation of the skin antiseptic, fungistatic and bacteriostatic effectiveness of bis (dichloropheny) iodonium chloride indicated that this compound is valuable as a dermatologic pharmaceutical, because of its definite reduction of transient and resident microflora of the skin. A 1.5% solution showed fungistatic activity in dilutions as high as 1:1000. The compound also showed a bacterial reduction of 90 to 95 per cent of the initial count, when used daily for 15 days. The substance proved to be nonirritating and nonsensitizing when applied continuously for 72 hours. At high dilutions, however, only a moderate inhibition was noted of gram-negative bacteria.

Cutaneous Elasticity and Hyperelasticity, F. E. Ellis and W. R. Bundick. Arch. Derm. 74: 22-32, 1956.

Since deviations in elasticity of the skin is frequently observed, a survey was made of 500 routine patients to determine the incidence of this abnormality. A chart is presented showing variations in hand size and changes suggesting generalized diseases. Mild degrees of hyperelasticity are usually overlooked. Increased elasticity of moderate degree was found in 18 per cent of the group studied. The elasticity tends to decrease with age. It may be familial; of the parents or grandparents have some

degree of hyperelasticity, their children and/or grandchildren tend to show increased elasticity. Whether this characteristic is dominant or recessive has not been determined. Patients with severe elastosis may develop drooping ears, and dislocation of shoulders and other joints. The literature on the subject is reviewed. 22 references.

Insensible Perspiration, Mali, J. W. H. Acta physiol. & pharm. neerl. 4: 422-23, 1955.

The layer determining the slight permeability of the epidermis for water is the "transition zone" between living cells of the stratum spinosum and the dead cornified stratum corneum. On the trunk this zone is 0.03 mm. thick and has a fibrous structure. Water vapor permeates the epidermis of the soles only through the ducts of the sweat glands. Permeability of normal epidermis follows Fink and Henry laws. It is the small solubility of water on fatty substances of the transition zone (cholesterol) which apparently determines the slight permeability of the skin to water vapor.

DRUG THERAPY

Antifugal Activity of B-nitrostyrenes and Some Cyclohexane Derivatives, A. C. Huitric. Antibiotics 6: 290-93, 1956.

Antifugal tests were made of a number of substitute *B*-nitrostyrenes and cyclohexanes, using strains of *T. mentagrophtes, M. fructigena, B. cinera,* and *P. notatum.* The results obtained agreed in general with the McGowan concept that fungistatic activity in these types of compounds is related to their tendency to withdraw electrons from the double bond, in the nitrostyrene series, but the cyclohexane compounds proved less fungistatic and gave no evidence of such a relationship. None of the compounds was significantly active against the saprophytic penicillium notatum.

Cortisone and ACTH Treatment of Post-Traumatic Dystrophy of the Extremities, O. Noring and H. Paaby. Acta orthoped. Scand. 25: 122-28, 1955.

Eighteen patients aged 22 to 68 had post-traumatic dystrophy of the extremities. The symptoms consisted of pain, trophic changes (skin atrophy, edema, nail changes or roentgenologic bone changes); neurologic changes (paresthesia, disturbances in sensibility); vascular changes (color, temperature of skin, or vasomotor changes) and reduction in motility. Seven of the patients had all of these symptoms to a considerable degree; they were fairly severe in the others. Nine had been previously treated with nerve block; 7 had physiotherapy. ACTH injections were given to 17 patients for 1 to 4 weeks, 10 to 12 units daily or every other day. Five received cortisone in tablet form for 2 to 6 weeks, rising in dosage to 25 mg. four times daily. One received cortisone for only 11 days. Recovery occurred in 1 patient in 14 days; 5 improved, 1 was unchanged; these were the severe cases. Of the 11 with moderately severe disease, 2 completely recovered, 8 improved and 1 remained unchanged. Although all these patients received other therapy besides cortisone and ACTH, it was evident that these drugs favorably influenced the results.

Effect of Procaine on the Function of Striated Mammalian Muscle, Egil Gjone. Acta pharmacol. & toxicol., Kbh., 12: 47-64, 1956.

Procaine administered intravenously to rabbits produced pronounced effect on tetanic contractions and high frequency inhibition. The protective effect produced by procaine against physostigmine and neostigmine is not believed to depend solely on the procaine but also on the effects of cholinesterase (ChE) inhibition. Experi-

mental data are presented to support the hypothesis that the action of procaine on the conductility of the finer nerve branches is responsible for this high frequency inhibition.

Inhibition of Inflammatory Response of Skin to Staphylococcus Aureus by High Polymer Levan, M. Shilo, M. Wolman and B. Wolman. Brit. J. Exper. Path. 37: 219-21, 1956.

Experiments conducted on laboratory rabbits and guinea pigs showed that high polymer levan inhibits the exudative phenomena of acute inflammation if given up to 8 hours before the animals are inoculated with bacteria; no shock is produced by the levan. A spreading dermonecrosis appears in the infected area within 4 to 6 hours. If levan is given 5 hours after inoculation the inflammatory response is interrupted by the levan, and a black necrotic area appears.

MEDICAL PRACTICE; GROUP PRACTICE

How Much Companies Pay for Medical Services, D. M. Thompson. Indust. Med. & Surg. 25: 317-22, 1956.

A study was made of per-employee cost-range in 135 companies. About 53 per cent pay from $10 to $20 per person, the number of persons employed ranging from 500 to 100,000. Three companies paying $60 per employee have extensive medical programs, including periodic examinations and provision of full-time nursing service. In 81 companies reporting salaries of full-time doctors, 123 such doctors received from less than $6,000 to more than $30,000 annually; 64 of these men earned $10,000 to $15,000; usually the highest salaries go to the medical director. Part-time fees are on hourly basis, per visit basis, salary fee or retainer fee plus hourly rate. The hourly rate ranges from $3 to $20. Most of the nurses and medical technicians receive $3,000 to $5,000 annually. The total costs of medical services cannot be exactly given, as different employers do not include the same items of expense. However, expenditures for medical services indicate that medical and health programs for employees have progressed during the last decade.

Academic Preparation for Health Education, H. R. Leavell. Am. J. Pub. Health 46: 581-84, 1956.

Representatives of ten schools of public health in the United States and Canada held a conference on preparation of health educators. These schools require a bachelor's degree, but require from no experience to 3 years of experience for admission. Required courses include public health administration, biostatistics, epidemiology and environmental sanitation; otherwise there was a wide difference in required and elective studies. Opportunities were offered in hospitals, health centers and medical care programs. The need for a sounder basis for planning the curriculum in schools of public health was stressed. An analysis needs to be made of the present status of health educators in official and volunteer agencies regarding job description, perception of health educator and employer regarding adequacy of preparation for the job, the role of the health educator, his activities in the future and the adequacy of the assistance rendered by him. Also analysis of the jobs, the reason for their creation, number of changes in personnel and relation of such changes to preparation of the worker. Consideration should be given to the importance of providing the health educator with specific knowledge of the behavioral sciences and tools and techniques of health education. Furthermore, there is need for adapting the teaching to the needs of the broad and rapidly changing fields of public health.

MUSCULOSKELETAL SYSTEM

Avascular Necrosis Involving Articular Surfaces, W. E. Gallie. J. Bone & Jt. Surg. 38-A: 732-38, 1956.

If a portion of the articular surface of a joint breaks free so that it is completely detached from its circulation, the bony part of that piece dies, whereas the articular cartilage part continues to live, as shown in cases where the head of a femur has been removed in non-union. About a year later the femur is seen to be covered with living hyaline cartilage, but the adjoining bone is avascular and necrotic. This is due to the ability of the hyaline cartilage to extract from the joint fluids what it needs for survival of its cells; the bone cells, however cannot survive without blood circulation. Therefore when blocking of the circulation occurs in fractures and bone injuries, avascular necrosis of the bone follows. If circulation can be established, invasion of osteoblasts occurs and new bone evolves. Three cases are discussed where arthroplasty was attempted by transplantation of autogenous articular surfaces; the fractures were in an elbow, a hip and a shoulder. Success attained in these cases suggests that the principle can be employed in other instances, for example, the articular surfaces of a talonavicular joint might be removed and transplanted to a hip joint. The subject deserves further study, since arthroplastics with introduction of cups and other prostheses now in use are crude attempts at repair of injured joints.

Metaphyseal Fibrous Defects, J. B. Cunningham and L. V. Ackerman. J. Bone & Jt. Surg. 38-A: 797-808, 1956.

These eccentrically located, asypmtomatic cystic lesions usually are located in the lower extremities of children and young adults. They are seen radiologically as well marked, radiolucent, uniloculated or multiloculated cyst-like areas in the metaphyses of the long bones. Microscopically they are shown to consist of cellular fibrous tissue with whorls and sheets of cells and varying numbers of nucleated giant cells and a few foam cells. The lesion must be differentiated from that of fibrous dysplasia unicameral bone cyst, oteomyelitis and tuberculosis. There is no evidence of new-bone formation, nor of malignant transformation or uncommon mitotic activity. The lesion seems to arise as a result of an unknown process within a small area of the epiphyseal plate which intermittently produces fibrous tissue instead of bone, but trauma may play some part. Regression of the defect has not been explained.

Osteochondritis Dissicans of the Ankle Joint: Report of a Case Simulating a Fracture of the Talus, B. M. Cameron. J. Bone & Jt. Surg. 38-A: 857-61, 1956.

Formerly treated by surgery, these cases are now being treated successfully by immobilization of the involved joint. A case is reported of a 21-year-old seaman who sustained a severe varus sprain of the left ankle while wrestling. Roentgenograms were made at intervals during five months when the fracture was treated with a weight-bearing plaster boot. His condition which responded well to immobilization regressed when the cast was removed, and finally healed when sufficient immobilization was applied. This seems to support the belief that in the ankle osteochondritis dissicans with formation of a loose body represents either a fracture progressing to non-union, or fracture with non-union already established. Furthermore it indicates immobilization, if begun before true non-union is present, and maintained until union is completed, the changes are reversible.

Some Applications of the Functional Anatomy of the Ankle Joint, J. R. Close. J. Bone & Jt. Surg. 38: 761-81, 1956.

A very frequent complicating factor in ankle fractures is diastasis of the tibiofibular syndesmosis, with widening of the ankle-joint mortise. This indicates injury to the medial or lateral ligaments of the ankle and tearing of the ligaments of the syndesmosis. The anatomy and function of the ligamentous structures of the ankle are reviewed and well illustrated. The function of the syndesmosis and its ligaments and the deltoid ligament was experimentally studied in 10 dissected fresh specimens obtained from above-the-knee amputations. The study showed individual sectioning of the syndesmosis ligaments only slightly affected the ability of the malleoli to separate, but progressive sectioning resulted in an increasing ability of the fibular malleolus to rotate laterally when the foot rotates laterally on the fixed leg. When all ligaments of the syndesmosis and interosseous membrane are sectioned, there is posterior displacement of the lateral malleolus up to 4 to 5 mm. through lateral rotation of the talus. The lateral malleous is more susceptible to posterior displacement than to anterior displacement, due to the nature of the groove in the tibia in which the fibula lies. It is frequently difficult to accomplish complete reduction of the medial clear space when treating the fracture, even after open reduction and fixation of the lateral malleolus; the deep portion of the deltoid ligament and of the posterior tibial tendon may be trapped in this space. This may necessitate open reduction for repair of the injured deltoid ligament. 34 figures.

Observations on the Postural Mechanism of the Human Knee Joint, J. W. Smith. J. Anat. 90: Pt. 2, 236-58, 1956.

It has been experimentally established that the muscles capable of affecting stability at the knee joint during standing are the extensors in the child, whereas in adolescents and adults, the center of gravity of the body falls in front of the axes of the knee joints, and the angle between leg and thigh exceeds 180°, so that in the older individuals the quadriceps muscles cannot control the knee joint position; therefore, ability to perform this function is transferred to the flexor muscle group. In the study here reported investigation is made regarding the nature of the *passive* mechanism resisting extension at the knee joint, and what contribution it makes to stabilization of the knee in various postures. It is postulated that this passive resistance is composed of two factors operating in harmony: (1) the resistance exerted by the articular mechanism demonstrated by Goodsir, or "articular resistance," and (2) that exerted by all the extra-articular structures stretched by movement of extension, or "extra-articular resistance." The elastic properties of the articular and extra-articular tissues, and the influence of these properties on the nature of the resistance are described at length.

Evidence has shown that tissues involved in articular mechanism are not rigid, but rather, each is considerably distorted by stress of normal dimensions, and within certain limits each tissue reacts elastically when stress is relieved. Articular mechanism operating at the knee joint is diagrammatically illustrated, showing the knee in three different positions. It is suggested that the exact limit of extension at the knee joint varies with the magnitude of the extending force; also that in relation to all but the smallest extending force, terminal degrees of joint movement are permitted by tissue distortion only, therefore being resisted in increasing measure by distortion stresses in those tissues. The extra-articular tissues which by exerting resistance to

stretch, exert passive resistance to knee joint extension, consist of the flexor muscles, together with deep fascia and skin over the popliteal fossa.

Experimental assessment is made of the total passive resistance to extension, of articular resistance to extension and of the extra-articular resistance to extension. Results indicate that over the range in which these two mechanisms operate together, the extra-articular is the greater factor. Measurements were determined of contributions of postural muscle activity and passive resistance to extension to the stabilization of the knee joint during symmetrical and asymmetrical standing. The angulation of the knee joint in walking and running is also described. 18 figures.

Fractures of Metacarpals, Metatarsals and Phalanges. L. W. Carlander. Minnesota Med. 39: 301-02, 1956.

Fractures of the phalanges of the toes may be treated by use of shoes with stiff soles and relief of pressure on the top of the toe from the upper portion of the shoe while the toe is swollen and painful. Traction is advised only for fractures extending into the articular surface at the metatarsal-phalangeal articulation. Metatarsal fractures are treated by use of a stiff-soled shoe with reinforced shank and proper longitudinal and anterior arch supports, or a well-applied short boot cast carefully molded beneath the foot and application of a walking heel. Occurrence of "march" or "stress" fractures of the metatarsals should not lead to consideration of biopsy or amputation for bone tumor. The treatment of fractures of the fingers is described as quite different from those of the toes.

Paralytic Flat Foot Treated by Triple Tendon Transplantation, A. C. Bingold. Proc. Roy. Soc. Med. 49: 181-83, 1956.

A girl was presented, aged 7, who had poliomyelitis at 2, leaving a flat left foot as a result of complete paralysis of the left tibialis anterior and posterior. When 6 years old, a triple tendon transplantation was performed: the heel cord was stitched to the inner side of the calcaneum, then the tibialis posterior tendon divided 2 inches above the medial malleolus, and the distal end stitched to the extensor hallucis longus tendon in front of the ankle, and the peroneus brevis tendon stitched to the tibialis posterior tendon close to its insertion. A plaster cast was worn for 5 months; 19 months after operation the shape and function were satisfactory. Should this correction be lost or a new deformity develop, external splintage followed by a triple arthrodesis would be considered.

Spastic Pes Varus, R. H. Maudsley. Proc. Roy. Soc. Med. 49: 181, 1956.

A brief description is presented of an unusual case of spastic pes varus in a 10-year-old girl who had pain in the right foot for 8 months, which was gradual in onset. There was no history of trauma. The foot was held in a moderate degree of varus, there was spasm of the tibialis anterior, eversion was resisted, and she walked on the outer border of the foot. The other foot was normal except for slightly restricted inversion. X-ray examination showed well-marked bilateral calcaneonavicular articulations. X-rays two years earlier, after slight trauma to the right foot, revealed no abnormality. Under general anesthesia the foot was brought to the neutral position and a walking plaster applied; pain was relieved. When the cast was removed 3 months later, pain recurred; physiotherapy was ineffective. It was generally agreed that the bony bridge was the cause of rigidity rather than spasticity, the latter probably being traumatic in origin. Active treatment was delayed until the child should reach the age of 12, when a

triple arthrodesis should be considered if symptoms indicated surgical treatment.

NERVOUS SYSTEM

The Nature of Pain, J. D. Hardy. J. Chronic Dis. 4: 22-51, 1956.

The theories regarding the nature of pain of old and modern writers is reviewed. Pain sensation with its special structural, functional and perceptual properties is only one part of a larger experience, termed "pain experience." This includes with the sensation of pain all associated sensations, emotional reactions and affective states; pain, then, differs in an individual according to the circumstances at that time. An extensive study of sensation and identification of its conscious dimensions is described, as measured in a group of 150 women and men, aged from 14 to 70, from hospital wards and laboratories. Each was asked before testing to express an opinion regarding his or her pain sensitivity. No significant correlation was found between personal estimation of hypersensitivity or hyposensitivity and the measured pain threshold. When nociception threshold and pain threshold were experimentally determined, it was found skin temperature of 45°C. is critical for pain, nociception and tissue damage; however, pain and nociception are evoked when that temperature is reached, but to produce tissue damage that temperature must be held at that point for many hours., thus the first two must be related to the rate of tissue damage, not to tissue damage itself.

Measured either by pressure or heat, the pain threshold is precise, indicating that a specific kind of stimulation begins at the pain threshold and is not present below it. Noxious stimulation and tissue damage both have the same threshold and both depend upon skin temperature above the threshold. Noxious stimulation seems to depend upon destructive reactions exceeding reparative reactions at the pain-fiber ending. Pain is an early warning that destructive forces are equalling the forces of repair. This concept can lead to a better understanding of the mode of action of analgesics.

Current Concepts of the Pain Process, F. P. Haugen. J. Chronic Dis. 4: 4-10, 1956.

Following a review of earlier studies on pain, a new concept is presented, as developed in the "pain clinic" of the University of Oregon. Past investigations of sensory mechanisms have been devoted to studies of the peripheral receptor rather than, as now, study of the patterning of nerve fiber impulses. The receptor is regarded as a sensory unit which imparts a pattern to nerve impulses aroused by stimulation of the receptor. Customarily the nervous system is thought of as consisting of various levels, each dominated by the one above—spinal cord, medulla, subcortical centers, cortex; the functional unit is the simple reflex. All sensory modalities are projected to the cortex which more or less controls the lower motor mechanisms; the frontal lobes occupy the top role in the hierarchy. The present concept is that the central nervous system is a dynamically plastic functional whole, every part of which down to the simplest reflex is very complex. "Pain" is a sensory perception, a subjective psychologic experience, with "awareness" an essential element; nothing can be considered as pain unless it is "felt" as such. Since the body functions as a single unit, anything upsetting its equilibrium, for example disease and pain, motivates a chain type of reaction in order to achieve homeostasis; this includes the nervous system.

A hypothetical "vertical" (instead of horizontal) organization of the nervous system, as related to transmission and perception of pain is presented, with a transactional component interposed between the sensory input and motor outflow, in a

continuity extending from top to bottom. Since "memory" lies within the transitional component, the pattern of a sensation such as pain may be altered by normal or abnormal activity within this diffusion system.

NEW GROWTHS

Primary Skin Cancer of the Fingers Simulating Chronic Infection, H. T. John. Lancet 1: 662-64, 1956.

The commonest forms of this unusual lesion are squamous cell carcinoma and malignant melanoma; these are often confused with septic lesions. Five cases are discussed in patients aged 50 to 76. The type of lesion in these cases and the treatment are as follows: (1) squamous cell carcinoma, with amputation of the thumb; (2) squamous cell carcinoma in the web of the first left space, with wide excision; (3) melanoma with amputation of the thumb; (4) squamous cell carcinoma, with amputation of the index finger; (5) melanoma of the thumb, with removal of the terminal phalanx and head of the proximal phalanx; this melanoma recurred in 9 months in the skin of the forearm, and the patient died of metastasis to the axilla. Prognosis in such cases depends on the extent of the growth before treatment begins. In squamous cell carcinoma the prognosis is excellent if excised before metastasis occurs. Biopsy is required in any lesion of the fingers which does not respond to therapy.

PHYSICAL MEDICINE: REHABILITATION

Return to Full Duty Following Surgery, D. S. Wenger. Indust. Med. & Surg. 25: 307-09, 1956.

An early return to work following an operation benefits the patient physically and psychologically and is of concern to the industrial physician to prevent extended loss of hours. Healing of trauma is accelerated as shown in the increased repair in leg fractures when the patient walks in a cast as compared with his immobilization in bed. If feasible the patient may be returned to partial duty or even full-time duty. Earlier ambulation has greatly decreased cases of pulmonary embolus after operations. In 7,200 surgical cases in the Air Forces, one embolus was reported in 1952 and none in 5,700 cases in 1953. The days lost following injuries and operations are listed. Those of the extremities were: simple fracture of radius and ulna (65 cases) 22.2 days lost; simple fracture of tibia and fibula (128 cases) 38.7 days; sprains of shoulder (62 cases) 5.4 days; sprains of ankle (880 cases) 5.3 days; sprains of sacroiliac (409 cases) 7 days lost. These various groups were samplings from Air Force cases.

RHEUMATIC DISEASES

Palliative Surgery for Rheumatoid Arthritis, J. Bastow. Rheumatism 12: 12-18, 1956.

The purposes of palliative surgery for rheumatoid arthritis is biopsy to establish the diagnosis, halting of the progress of the disease locally by excising diseased tissue, correction of deformity, and restoration of function. Unless biopsy is done, synovial tuberculosis, villo-nodular synovitis, synovioma, infective arthritis and gout may be mistaken for non-articular rheumatoid arthritis, or vice versa. Exploration of the knee joint is done preferably by an open arthrotomy rather than by needle biopsy. This procedure is described.

Excision of diseased tissue includes excision of rheumatoid nodules, of abnormal bursae, inflammed tendon sheaths, and synectomy of rheumatoid joints. Description is given of these various techniques. Correction of deformity may be done (1) by manipulation under anesthesia to correct flexion contractures and adduction

contracture; (2) closed tenotomies, for example, to correct fixed equinus deformities of the ankle, clawed toes and adducted hip; (3) open operation in dealing with severe flexion contractures of the knee not responding to manipulation; (4) restoration of function of hands, wrists, elbows, shoulder, foot (toe-joints, tarsal joints), ankle, knee, hip joint.

In correction of toe joints with deformities such as clawing of toes, hallux vagus and bunion many procedures are used. Closed tenotomy of contracted long flexors and/or extensor tendon may afford relief in early cases. In some advanced cases excision of the metatarsal head may be necessary. A Keller's operation with excision of exostosis on the medial side of the metatarsal head may be required in hallux vagus; in other cases arthrodesis of the great toe joint in the functional position of slight dorsiflexion is preferable. Amputation of all toes in neglected cases may be required to allow wearing of reasonably fitting shoes.

Infection, Allergy and the Pathogenesis of Rheumatic Disease, Gösta Hagerman. Acta rheumat. scand. 1: 204-34, 1955.

Facts and theories in the field of allergy and immunology may be applied also to the study of rheumatic disorders. Many writers have supported the idea that a bacterial allergy is, at least partly, the cause of rheumatic disease. The nature of the allergic phenomena causing the clinical symptoms has been variously ascribed to tuberculin-type allergy, delayed action allergy of infection, and to a form of autosensitization against the body's substances, especially in the joints. A detailed synopsis of the most important immuno-biologic reactions and their tentative relationship to rheumatic disease is presented. Vaughan has remarked on the simultaneous occurrence of recognized allergies and rheumatic disease. Long has advanced the hypothesis that susceptibility to rheumatic fever and sensitivity to bacterial allergens are the same thing. The author believes that pathogenically rheumatic fever is on a par with the "microbids" (tuberculids, trichophytids, etc.) found in many sensitizing infections. He notes, however, that the finding of different antibodies (antistreptolysins, etc.) against *B*-streptococci in serum, while suggesting an etiologic connection between these organisms and rheumatic disease, provides no conclusions as to the pathogenic mechanisms, since these antibodies are chiefly active in immune defense.

The recognizable signs following elapse of the specific sensitization time in immuno-biologic transformation are: a positive skin reaction, an altered immunologic response, and an allergic spreading phenomena referred to as "ids" or microbids; this pathogenic mechanism is described, together with the influence of specific lipoids and the theories regarding organ-specific "mediators." Experiments to induce rheumatic disease in animals seem to support the assumption that acute rheumatism is an expression of altered sensitivity to repeated infections by group A streptococci of varying serologic types. Further investigations may prove other microorganisms of importance in causing symptoms typical of rheumatic diseases. The reason that the joints and no other organs are affected is that these patients have a tendency to sensitization, with the joints acting as shock organs, probably a hereditary tendency. After repeated acute attacks a stronger and stronger autosensitization develops against the cartilage, joint capsule and/or periarticular tissue, possibly by means of organ-specific "mediators." This form of allergy produces the irreversible, destructive, chronic changes in the joints.

The suggested treatment is hyposensitization to all common types of *B*-streptococci,

and to other groups of streptococci. Antigens suspected of causing clinical symptoms should be used, given in much smaller and more frequent doses than the immunizing antigens, with doses slowly increasing.

Clinical Evaluation of Prolonged ACTH and Cortisone Therapy in 114 Cases of Rheumatoid Arthritis: a 3½-Year Study, J. H. Solem and O. Römcke. Acta rheumat. scand. 1: 243-49, 1956.

Of 114 patients treated, 2 were in stage I of the disease, 29 in stage II, 40 in stage III and 43 in stage IV; duration of rheumatoid arthritis at the beginning of hormone therapy was on the average of 1¾ years in stage I, 5 years in stage II, 6¾ years in stage III, 13-2/3 years in stage IV. These stages are classified as: stage I, osteoporosis, without destructive changes; II, osteoporosis with or without slight cartilage destruction and muscular dystrophy, sometimes limited motion and extra-articular lesions; III, extensive atrophy, cartilage and bone destruction, osteoporosis; IV, same as stage III, but with fibrous and bony ankylosis. In cases where no improvement followed treatment, hormone therapy was discontinued after 2 months; otherwise duration of treatment in stages I, II, III and IV was 4, 8, 13, and 15 months respectively. Treatment was discontinued in 15 patients because of exacerbation of the disease during treatment. The side-effects were few and none fatal. Satisfactory improvement occurred in 30 per cent of patients. ACTH was administered to 65 patients, 20 I.U. Cortico-Depot, two to three times a week. Cortisone was given orally to 49 patients, on an average of 50 mg. daily, and maximum of 75 mg. daily.

Treatment of Gout, C. J. Smyth, E. R. Huffman and G. M. Wilson. Arch. Indust. Med. 97: 783-92, 1956.

Recent advances in the treatment of acute and chronic gout, as reported in the literature show more favorable results than are obtained in other types of arthritis, but lifelong treatment is necessary. Acute attacks can be controlled by oral or intravenous colchicine, demecoline (Colcemid), and phenylbutazone (Butazolidin). Probenecid (Benamid) while ineffective in single bouts of gouty arthritis, is important in long-term treatment of chronic gout. The use of steroid therapy is not recommended unless all other therapies have failed. Hydrocortisone acetate and also the new TBA may produce great improvement for two to four hours, but unless accompanied by systemic therapy this improvement may be followed by a flare-up of the joint inflammation. Treatment of the various stages of gout and dosages are described. 30 references.

SURGICAL ARMAMENTARIUM

A Simple Method of Elastic Splinting for Thumb Web, H. Bjerner and E. Moberg. J. Bone & Jt. Surg. 38-A: 910, 1956.

A splint to widen a contracted thumb web is described. A rubber or elastic tube of given size is split along its length and the concave surface placed along the web as illustrated. Tension is relieved by cutting away different amounts from the split sides of the tube. Adhesive tape is used to line the tube and also to keep it in place. The splint is also used to separate fingers swollen or contracted, for example, after surgical treatment for Dupuytren's contracture.

X-RAY

Significance of Periosteal Reactions, L. C. Collins and V. P. Collins. Texas State J. M. 52: 144-50, 1956.

Periosteal new bone is laid down in cases of inflammation, infection, trauma, neoplasm, metabolic disturbances, and physiologic variations. Diagnosis of each type is

described. Diagnostic criteria in inflammation are age of patient at onset of the disease up to 5 months; polyostotic distribution; periosteal bone smoothly laminated or irregular; edema of the soft tissues, and spontaneous regression. Diagnostic criteria of periostitis resulting from infections are localized involvement; destruction of adjacent bone; edema of adjacent tissue, and clinical evidence of inflammation. Trauma is the most frequent cause of periosteal shadows; diagnosis is established by history of injury, the relatively smooth, uniform character of the calcification, indicating a benign process, and progress of the process during the first two or three weeks indicating it is a reparative process, not a destructive lesion.

Any malignant tumor may produce a periosteal reaction through invasion or destruction through the cortex. The diagnosis is made by the presence of localized periosteal reaction, destruction of adjacent bone, the presence of extra osseous soft tissue mass, and of spicules of periosteal bone. A common physiologic variation is the irregular calcification along a long bone at the site of tendinous attachment or attachment of the interosseous membrane (in leg or arm). Another example is the double cortical line showing involvment of a few or all the long bones of the extremities. Diagnostic features are age of the patient (2 to 6 months), symmetrical distribution, presence of a slender periosteal shadow along each bone, without edema or clinical symptoms. When periosteal new bone with no evidence of associated bone destruction is noted in adults, it is pathognomonic for hypertrophic pulmonary osteoarthropathy, indicating an intrathoracic lesion, probably bronchogenic carcinoma.

Why People Seek Diagnostic X-Rays, G. M. Hochbaum. Public Health. Rep. 71: 377-80, 1956.

Of the 1,200 persons interviewed in three large cities, 41 per cent voluntarily without symptoms of disease had obtained one or more X-ray examinations for tuberculosis; another 16 per cent volunteered for such examinations because of suspicious symptoms; 14 per cent had X-ray examinations because of pressure of someone or because X-rays had been requested for some special reason. A few had such checks because of heart or lung conditions. Only 10 per cent never had an X-ray examination. The three factors which determine whether an individual decides to obtain a chest X-ray are: (1) He believes he might get tuberculosis; (2) he is convinced he might have tuberculosis sometime without noticeable symptoms; (3) he believes that early detection of the disease will lessen problems and worries that may arise if he should contract the disease. Many persons worry less about prognosis and difficulty of treatment, and more about losing their jobs and income, shattering of their careers, and imposing a burden on their families.

Xeroradiography, E. W. White, X-Ray Tech. 27: 28-31, 1955.

This is a method of making radiographs without use of x-ray film and wet processing. The xeroradiograph may be viewed within 50 seconds, after exposure. No darkroom is required. Radiographs are not suitable for heavy parts such as the spine and abdomen. They have been used mostly in study of pathological specimens and in study of the extremities of the dog. Appliciation to general hospital radiography may evolve from further studies.

ORGANIZATION NEWS

Secretaries of local, state, regional, affiliated, subsidary and other related organizations are invited to submit copy for this column.

ALABAMA

The annual meeting of the Alabama Association of Chiropodists was held on March 2-3, 1957 at the Whitley Hotel in Montgomery, Ala., with Dr. T. H. LeCroy, President, presiding.

The following officers were elected:

President
Dr. W. J. AuCoin
Vice President
Dr. J. C. Coleman
Secretary & Treasurer
Dr. Elizabeth P. Sealy
Board of Trustees
Dr. John Cooper, Chairman
Drs. G. B. Crowley, J. B. White
J. G. Veres, Associates
Prosecution
Dr. Stanley Frank
Legislation
Dr. G. E. Clark (two-year term)
N.A.C. Delegate
Dr. P. D. Wilton
N.A.C. Alternate
Dr. G. E. Clark
Medical Board of Examiners
Dr. G. E. Clark (three-year term)
Drs. T. H. LeCroy, Ed Sealy, Advisors

Dr. George W. Benitez reported on the National Association of Chiropodists' meeting in Chicago. Dr. G. E. Clark presented a plan for legislative action.

Plans were discussed for the Region Ten Zone meeting to be held in Montgomery, September 6-8. 1957 by Drs. Elizabeth P. Sealy, President, and G. E. Clark, Scientific Chairman.

FLORIDA

The Chiropody Association of Florida will hold its 35th Annual Convention and Scientific Conclave in Tampa on May 30-31, and June 1, 1957 at the Floridan Hotel.

Dr. M. K. Upshaw, Jr. will represent the

"LIFE'S FOUNDATION — YOUR BABY'S FEET" is an outstanding and comprehensive booklet on the growth and care of children's feet. Written for the layman, it is concise, cleverly illustrated and will prove valuable especially to the parents of young children. Many Chiropodists have received a copy of this booklet and have ordered them in quantity. For those of you who have not ordered and for those who wish to reorder, please clip the order blank below and mail with your check for your supply.

WOMEN'S AUXILIARY
NATIONAL ASSOCIATION OF CHIROPODISTS
2035 WEST ALABAMA, HOUSTON 6, TEXAS

Please ship to me "Life's Foundation — Your Baby's Feet" in the quantity marked:

100 copies	$3.50	☐	P. P. Prepaid
500 copies	16.00	☐	P. P. Prepaid
1,000 copies	29.00	☐	P. P. Prepaid
5,000 copies	136.00	☐	Express Collect
10,000 copies	250.00	☐	Express Collect

Check payable to Women's Auxiliary, NAC, in the amount of $_____ is enclosed.

NAME _____

STREET ADDRESS _____

CITY and STATE _____

SEE THE EXHIBIT AT YOUR REGION CONVENTION

National Association of Chiropodists' Executive Council and will speak at the session.

The State Scientific Chairman, Dr. M. M. Marcus, will preside and moderate a Diabetic Panel Symposium. Dr. William Ellison will speak on the Diabetic Clinic. H. Phillip Hampton, M.D., Director of the Tampa General Hospital Diabetic Clinic, will sit as panelist as will Miss A. Radakowski, R.N., Public Health Nurse. The Symposium will include slides and patients from the Tampa clinic.

Dr. Norman E. Lawrence will lecture and demonstrate Corticosteroid Injection Therapy. Dr. George Horn will present a monograph on Clinical Application and Indications for Antibiotics. Dr. Charles W. Corbett and Dr. Erwin F. Wunderlich are scheduled to present a paper on X-Ray and Laboratory Report Interpretations for Surgery. Dr. Joy E. Adams will demonstrate and lecture on Clinical Dermatology.

Mr. George Owen, Assistant Attorney General of Florida, will discuss the Import and Interpretation of the Florida Chiropody Law.

NEBRASKA

The Nebraska State Association of Chiropodists held their last meeting Thursday, February 14th, at the Castle Hotel in Omaha, Nebraska.

Dr. Donald T. Gartner presented a lecture on chiropodal surgery utilizing X-ray studies of individual cases. A business meeting was also held.

NORTH CAROLINA

The North Carolina Chiropody Association held its first Mid-Winter Scientific Conclave at the Hollywood Hotel in Southern Pines, N. C. Dr. B. C. Egerter of Pittsburgh, Pa., was guest lecturer for the scientific session.

A Pilot Committee was formed to establish an assistant's program in the state.

WHEN A WET DRESSING IS REQUIRED . . .
DOMEBORO®
RECOGNIZED THE WORLD OVER AS THE FINEST OF ALL WET DRESSINGS
When you need a wet dressing as, for instance, with diabetic foot lesions, use DOMEBORO tablets or powder because this finest of all Aluminum Acetate wet dressing is the modernized Burow's solution. It increases drainage and encourages separation of viable and dead tissue. It produces a solution buffered to a pH of 4.2, dermatologically correct for the skin. Stays moist longer, requires less patient attention.
DOMEBORO
AVAILABLE in convenient single-dose Powder Packets and Tabs and economical bulk powder.
DALI-DOME® powder for Whirlpool baths.
Domeboro Tabs
DOME CHEMICALS INC.
DOME CHEMICALS INC.
109 W. 64th ST. NEW YORK 23, N.Y.

PENNSYLVANIA

Lehigh Valley Chiropody Society

The February monthly meeting of the Lehigh Valley Chiropody Society was held at the Lehigh Valley Club in Allentown, Pa. The following officers were elected for two-year terms; President, Dr. N. S. Reitter; Vice President, Dr. Michael Finelli; Secretary-Treasurer, Dr. Paul N. Lipp; Council Members, Drs. R. Alexander, Leon Kehr and Richard Shaw; House of Delegates, Drs. M. K. Detweiler, H. Hunsicker and N. Enea; Diabetic Board of Directors, Dr. David Hay.

Plans for the annual banquet were formulated and the affair will take place at the Parkway Manor Inn in Allentown, Pa., on May 11, 1957.

Drs. David Hay and Leon Kehr have been appointed to the Allentown State Hospital to do chiropodial work.

TEXAS

Bexar County

At a recent meeting of the Bexar County Chiropody Society, Dr. Louis Bogy was elected President and Dr. Charles Fladger, Secretary-Treasurer.

After the business meeting, a film relative to the treatment and diagnosis of gouty arthritis of the foot was shown.

WEST VIRGINIA

The Region Eight Convention will be held at the Pritchard Hotel in Huntington, W. Va., October 4-6, 1957.

The following were appointed to convention committees: Convention Chairman, Dr. H. Darrel Darby; Program Chairman, Dr. G. M. Arnold; Entertainment, Dr. L. W. Adkins; Advertising and Exhibitors, Dr. B. F. Kilgore; Scientific Chairman, Dr. E. R. Johnson; Promotion Chairman, Dr. J. J. Bates; Publicity Chairman, Dr. G. Taylor; Registration Chairman, Dr. E. H. Seibert.

A ladies' program will be held in conjunction with the convention.

NOW AVAILABLE

NEW 4" x 10 YD.

Non-Ravelling

DOME-PASTE® BANDAGE

DOME

The new Dome-Paste bandage is flesh colored, 4" x 10 yd. gauze bandage... impregnated with glygerine, zinc oxide, gelatine paste. Firmly woven with thread-locked edges to resist ravelling. Medicament spreads uniformly, and is easy to apply.

RECOMMENDED for leg ulcers resulting from diabetes, varicose veins and simple weak foot complaints.

Wrapped individually in sealed polyethylene bags, inserted in metal cans to insure freshness.

DOME CHEMICALS INC.

109 W. 64th ST. NEW YORK 23, N.Y.

NATIONAL CONVENTION PHI ALPHA PI FRATERNITY

THE Epsilon Chapter of the Phi Alpha Pi Fraternity of the Ohio College of Chiropody was host for the national convention of the Phi Alpha Pi in Cleveland, Ohio, on February 1-3, 1957.

The following were elected to office for the year: Dr. George Dolinger, Dunmore, Pa., Grand Alpha; Dr. Louis Diamond, Chicago, Ill., Grand Beta; Dr. Anthony Sabatelle, Carbondale, Pa., Grand Kappa Tau; Dr. Alan Silver, Cleveland, Ohio, Grand Kappa Rho; Dr. William L. Anderson, Danville, Ill., Grand Scribe.

The convention program was as follows: Dr. Allen P. Joslin, "Diabetes and the Chiropodist"; Dr. William B. Ignatoff, "Re-evaluation of Verruca Therapy"; Dr. Ramon D. Jacobs, "Fabrication of Appliances"; Dr. Henri L. DuVries, "Value and Technique of Surgery in General Chiropody"; Dr. Malcolm A. Brahms, "Selective Denervation."

AMERICAN COLLEGE OF FOOT SURGEONS, INC.

Western Division

The annual meeting of the Western Division of the American College of Foot Surgeons, Inc., will be held this year at the Sheraton-Palace Hotel in San Francisco, California, on Sunday, June 2, 1957, at 9:00 a.m.

This meeting will be held in conjunction with the Western Chiropody Congress and the annual meeting of the California Association of Chiropodists, which will be at the same hotel from Thursday, May 30, 1957, through Saturday, June 1, 1957.

Applicants, who have met all other requirements and have been so notified, will be given their oral and written examination for certification in the American College of Foot Surgeons at this meeting. The morning session will be devoted to the transaction of all business matters to come before the Western Division of the American College of Foot Surgeons.

FOR THE FINEST IN LATEX SHIELDS

CUSTOM BUILT PROSTHETICS DESIGNED AND TAILORED
BY CHIROPODISTS FOR THE CHIROPODY PROFESSION
TO CASTS OR IMPRESSIONS

Hammer Toe

Bunion
and special types

Heloma Durum

LIQUID RUBBER APPLIANCE LABORATORY

489 HIGH STREET, NEWARK 2, NEW JERSEY

Prompt Service Send for brochure

For Members of

National Association of Chiropodists

NEW ESSENTIAL PROTECTION

$5,000.00 Major Catastrophic HOSPITAL INSURANCE

PAYS YOUR BILLS WHILE HOSPITAL CONFINED UP TO $5,000.00 FOR EACH ACCIDENT AND SICKNESS IN EXCESS OF THE DEDUCTIBLE AMOUNT WHICH IS EXCLUDED FROM COVERAGE.

(Your choice of $300.00 or $500.00 deductible Plans)

Including:

- Daily Hospital room and board
- Miscellaneous Hospital Expenses
- Doctors' calls at the rate of one visit per day up to a maximum of $10.00 per visit.
- 75% of Nurses' fees in hospital
- Surgeons' fees from $5.00 to $500.00 for operations according to schedule. Amount paid varies commensurate with the severity of the operation.

The following are not covered:

- Pregnancy, childbirth or miscarriage
- Mental Disorders
- War or any act of War
- Any military service
- Losses covered by Workmen's Compensation or Occupational Disease Law
- Treatment in Federal Hospitals

5 Special Features of this New Plan

- All covered expenses incurred within two years of the first hospital confinement for any illness or injury are covered up to $5,000.00, above the deductible of your choice.
- No restriction as to type or cost of daily hospital room and board.
- YOU choose the hospital — the doctor YOU want.
- Covers you anywhere in the world.
- Hospital "extras" not limited to any set amounts.

Underwritten by THE UNITED STATES LIFE INSURANCE COMPANY

Administered by

THE NAC AGENCY, Inc.

35 Market Street **Poughkeepsie, N. Y.**

STOP!! DON'T GAMBLE
IMPROPER FORCE STRETCHING
AND SEAM WEAKENING.

STELLA'S STRETCH-ALL

A LIQUID PREPARATION
GUARANTEED TO STRETCH
PERMANENTLY ANY SHOE MADE OF
LEATHER, IN LENGTH OR WIDTH

WILL NOT SPOT, SPLIT OR CRACK
THE FINEST OF LEATHER.

STELLA'S STRETCH-ALL

Send Name and Address of Your
Supplier for Free Sample.

F. P. STELLA & SONS PRODUCTS
NEW BUFFALO, MICH.

The afternoon session will be devoted to an elaborate scientific session. Robert L. Rutherford, D.S.C., F.A.C.F.S., as scientific chairman for the day, has prepared the program of which the theme is, "A Review of Fifteen Years of Chiropodical Surgery." Patients on whom foot surgery has been performed in this area through the past fifteen years will be presented. A review of the reasons for surgery; the type of procedure and the present results will then be discussed by a panel of fellows of the American College of Foot Surgeons.

Leo N. Liss, D.S.C., F.A.C.F.S.
Chairman, Western Division,
A.C.F.S.

ECONOMIC SURVEY UNDER WAY

A COMPLETE economic analysis of practitioners' incomes in New York State has been undertaken by the New York State Podiatry Society.

An Economics Committee, under the chairmanship of Dr. Donald Altman, has prepared a comprehensive, one-page ques-

OUR NEWEST MOULD

The Levy Latex Mould and Contour Inlay made completely of Latex and Sponge Rubber.

After many years of intense research and the cooperation of a prominent Doctor and Competitor, we have at long last succeeded in fulfilling the idea originated by Dr. Ben Levy **TO CUSHION THE FOOT.**

This product constructed of Sponge and Latex Rubber is far superior in comfort to any so-called space shoe, and, very important to our woman to-day, in no way mars the beauty of the shoe.

We strongly recommend it for those suffering from Arthritis, Circulatory or Diabetic conditions. Also for bony, rigid and sensitive feet as well as for Verruca, Ulcers and Scar Tissues. It also is made in an inlay type without crest.

The **ORIGINAL CONTOUR** is retained at all times.

A negative or positive Cast at right angle is necessary.

LEVY & RAPPEL, INC.
384 Columbus Ave., New York 24, N. Y.

tionnaire, which has been sent to every member of the Podiatry Society. In order to ensure complete accuracy of tabulation and reporting, a statistical firm has been engaged to transfer questionnaire replies to punched cards. As data is received, tabulation and cross checking will be done by machine.

In order to overcome the difficulties which have been experienced in the past and in order to ensure the receipt of accurate data, the consultants who participated in similar questionnaires for other professions were engaged to help prepare the basic questionnaire.

It is expected that within the next month, sufficient replies will have been received to permit the statistical agency to prepare preliminary reports.

When final tabulations have been made, a complete write-up of the survey will be prepared and made available to all members of the National Association of Chiropodists.

NEW FISCHER QUALITY PRODUCTS FOR THE CHIROPODIST

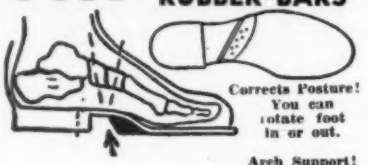
FISCHERQUARTZ - FISCHERTHERM
FISCHERSINE - PEDASINE
ULTRA SOUND

Valuable reprints for the asking
NO OBLIGATION

RF-7 Ultra Sound.

R. A. FISCHER & CO.
517 Commercial St.
Glendale 3, Calif.

FAY METATARSAL RUBBER BARS



Corrects Posture! You can rotate foot in or out.

Arch Support! Prevents shoe shank breakage.

Easy to attach to sole of shoe. Exercises feet. Five sizes. Rubber gives comfort. Doctor's Introductory Package: 15 pair assorted styles and positioning chart. Order of your JOBBER.

These Jobbers Will Supply You

Allied Surgical Supply, Lancaster, Pa.
C. H. Hittenberger, San Francisco
Chicago Medical Equipment Co., Chicago
Chiropody Supply Headquarters, Chicago
Chiropody Supply Headquarters, New York
Deer Products Co., Pittsburgh, Penn.
Edward M. Smith, Garrison, New York
General Chiropody Supply, Brooklyn, N. Y.
Julius Rothschild, Long Island, New York
Katzenstein Professional Supply Corp., N. Y.
National Medical Supply Co., Chicago
Service Surgical Supply, Chicago, Ill.
Surgical Supply Service, Philadelphia

CARL F. FAY ESTATE
3025 Farnam St., Davenport, Iowa

TESTIMONIAL DINNER FOR "PODIATRIST OF THE YEAR"

A TESTIMONIAL DINNER honoring Dr. Benjamin Kauth, the "Podiatrist of the Year," has been scheduled by the New York Division of the Podiatry Society. The dinner will be held at the Hotel Pierre on the evening of May 11th.

Dr. Kauth, who was voted New York State's "Podiatrist of the Year," received this honor in recognition of his work in last year's *Life* magazine article and for his initiative in helping New York practitioners to receive the right to use the designation "foot specialist."

Reservations for the dinner may be made by communicating with Dr. Donald Altman, 767 Lexington Avenue, New York, New York. Tickets for the affair are priced at $10.00 per person.

FOREDOM CHIROPODY DRILLS

CABLE and ALL CORD Models

FLOOR, WALL and CABINET Types

COMBINATION DRILL-VIBRATORS

PERCUSSION VIBRATOR ATTACHMENTS for Cable Drills

The ONLY Complete Line —

When you buy a FOREDOM, you get the BEST at a price which offers a challenge to imitators.

MODEL 39

PIONEERS . . . and . . . after 35 YEARS still the LEADERS!

At Your Dealer or write for COMPLETE CATALOG No. C11D

FOREDOM ELECTRIC COMPANY Dept. C11D, 27 Park Place, New York 7, New York

Memo:

Must complete arrangements to be in Chicago in August for the

NAC Convention

McDowell

OSCILLATOR

Helps You Correct Bunions and other FOOT AILMENTS

This professional adjunct to manipulation in Foot Orthopedics will enable you to realign bone structure and develop muscular rehabilitation completely and quickly.

The traction attachment gives up to 20 pounds pressure, and when applied under oscillation, treatment is positively painless.

Write for technical details.

McDowell Manufacturing Co.
Pittsburgh 9, Pa.

FOOT BALANCE INLAYS

are only completely
successful
when each case
is individually studied, diagnosed
and an inlay made to fit its
special requirements

The laboratory of

CARL G. BERGMANN, D.S.C.

5406 BROADWAY **CHICAGO 40, ILL.**

originator of foot balance inlays is directed
in all its endeavors to accomplish this result

MOOD ELEVATORS

Contributions to this column are more than welcome. In fact it depends upon them.

A.O.P.

The old engineer stopped his locomotive beside the water tank and instructed his new and green fireman how to handle the thing. The fireman brought the spout down, then got tangled up with the chain and stepped into the tender's tank.

As he floundered around in the water the engineer drawled, "Just let the water run in by itself, Son. You don't need to stomp it down."

The rookie didn't look just right to the Army psychiatrist. With a bit of suspicion in his voice he asked, "How about your social life? Ever go out with the girls?"

"Nope," said the soldier. "Just sit around mostly."

"Don't you ever want to?"

"Well, y-e-e-s, sort of."

"Then why don't you?"

"Wife won't let me, Sir."

A 20 year old man told police court Thursday he stole a car because his girl friend's feet were aching. Thomas Victor Martin, 1160 Comox, who pleaded guilty to charges of auto theft and contributing to juvenile delinquency, was remanded to November 16, for sentence. Prosecutor Paul Delany said Martin had told officers he stole the car on Oct. 20, because his girl friend complained of sore feet.

The Province, Vancouver, B.C.

Speaking of commemorative postage stamps, how about one with a picture of a weeping tax payer.

A bachelor is a thing of beauty and a boy forever.

A man in farmer attire and driving a creaky old car went through a red light.

"Hey!" yelled the crossing cop, "Didn't you see that red light?"

With a swift glance over his shoulder the driver said, "It's green now, Officer," stepped on the gas and beat it.

Wood Sole Acts As Splint

REECE ORTHOPEDIC SHOE

for

BROKEN TOES AND FOOT BONES
Burns - Bursitis - Sprains
Hastens Healing Post Operative Cases
Dermatitis and "Athlete's Foot"
Permits Aeration

No. 175 — Men's
No. 173 — Women's

Sizes—Small, Medium, Large

No lefts or rights — can be worn on either foot. Easily stocked.

Doctors say —
"This shoe reduces convalescence to a minimum"

- **Lightweight WOOD SOLE with airfoam insole acts as SPLINT.**
- **Canvas upper—white or olive drab laces easily over any size bandage.**
- **Saves time for doctors, nurses and patients.**

(MAY BE HAD WITH GUARD TO PROTECT FROM REINJURY)

ORDER TODAY

REECE WOOD SOLE SHOE CO.
Dept. CH-86 Columbus, Nebr.

After they were safely and solidly married the young man said, "Now that we are married I want you to give up all your girlish habits but one."

"And what is that one, dear?"

"You can go on taking your allowance from your father just as you have always done."

Fog—stuff that is dangerous to drive in; especially if it is mental.

Oh tiny germ, so fine, so small,
Where do you find the infamous gall
To strike me down into this bed
And hold your parties in my head?

The American Way

Natives who beat drums to drive off evil spirits are objects of scorn to smart American motorists who blow horns to break up traffic jams.

Cherokee (Iowa) Courier

Congratulations to the

Journal of the

National Association of Chiropodists

On Its Fiftieth Anniversary

CHICAGO MEDICAL EQUIPMENT CO.

17 North Wabash Avenue

Chicago 2, Illinois

CUSTOM FOOT APPLIANCES ARE BETTER THAN EVER.

We offer you a wide choice of materials and styles

★ **ORLON LAMINATED PLASTICS**

★ **CELASTIC BI-PLANE BALANCERS**

★ **LEATHER BI-PLANE BALANCERS**

★ **FLEXIBLE LEVY MOULDS**

★ **SEMI-RIGID LEVY MOULDS**

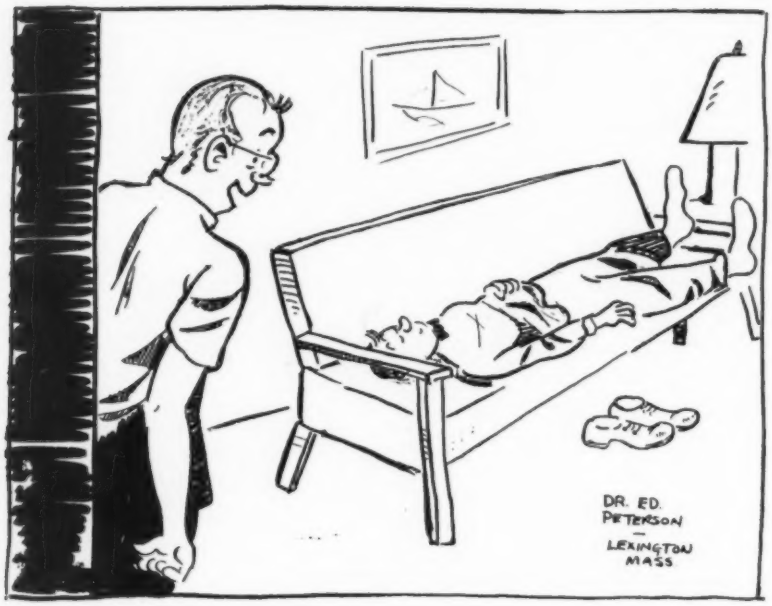
★ **FLEXIBLE LEATHER APPLIANCES**

Write today for our illustrated catalogue

ARCHCRAFT LABORATORIES

Manufacturing Custom Foot Appliances

1807 ARCH STREET PHILA. 3, PA.



"Been waiting long Mr Peters?"

LATEX AT ITS FINEST for 22 years,

by constant research, now presents

MICRO-SATIN BACTERIOSTATIC LATEX

Exclusively at LRAL Waterloo at usual fee

- ★ Actively antiseptic latex
- ★ Self sterilizing in effect
- ★ Mildew and fungi static
- ★ Self deodorizing
- ★ Reduces allergy potential
- ★ Micro-satin wears longer
- ★ Laboratory report on request
- ★ 24-hour splints for orthodigita

Special service to East and Far West

WRITE FOR COPY OF LECTURE ON 24-HOUR SPLINTS

NO OTHER LABORATORY HAS ANY CONNECTION WITH THE ORIGINAL LRAL WATERLOO

Send Rx and casts to

LIQUID RUBBER APPLIANCE LABORATORY

8th Floor, National Building, Waterloo, Iowa

Somewhere we read about a chap whose wife had quadruplets so he went out and bought a fifth.

Imp

Women do things for appearance for which used car dealers would go to jail.

Robert Yoder

One of the biggest troubles with success is that its recipe is often the same as that for a nervous breakdown.

Wall Street Journal

Suffering in silence isn't so bad if everybody knows what you're doing.

Arkansas Gazette

Lost: Light blue dress, night of Share-the-Fun Contest.

Classified ad in Blair (Neb.) Enterprise

Monaco weather forecast: a little Rainier in February.

New York Daily Mirror

Biter Bit

He was new in town and was already known as a tough bargainer, a complainer, slow pay, generally mean. The corner-store keeper, after repeated efforts to collect a bill, finally got him and made him pay up. The fellow said, "Put on that receipt that I don't owe you a single cent." The storekeeper receipted the bill, then wrote. "This guy don't owe me nothin' and by heck he ain't agoin' to."

It takes a lot of will to be a wisp.

Marjorie J. Marshall

BUTLER'S CHIROPODY SUPPLY CO.

Western Specialists in the Finest All Nationally Advertised Equipment

CHAIRS & STOOLS
RELIANCE
RITTER
PAIDAR

ULTRASONICS
LINDQUIST
BIRTCHER
FISCHER

INSTRUMENTS
CHIROPODY
SURGICAL

SUPPLIES

X-RAYS, WHIRLPOOLS, ALL MAKES

Every foot balancer made to specific prescription.

5541 York Blvd., Los Angeles, Calif. CLinton 5-3049

1069 Market St., San Francisco 3, Calif. UNderhill 1-4551

BUTLER'S

"The House of Friendly Service"

TERMS TO SUIT

WRITE FOR PRICES AND DETAILS

47% *of America's*

Chiropodists

have tried

NEURABALM®

Have You?

SOOTHING, LASTING MASSAGE

For tired, aching feet; Athlete's Foot; minor cuts, scratches, burns; sprains. Available through regular drug channels.

First in First Aid **NEURABALM®**

NRB 41 (NRB 2367)

CONVENTION DATES AND MEETING NOTICES

NATIONAL ASSOCIATION OF CHIROPODISTS
Chicago, Ill.
August 14-21, 1957
Drake Hotel

REGION THREE
Atlantic City, N. J.
April 25-28, 1957
Ambassador Hotel

REGION SIX
St. Louis, Mo.
May 3-5, 1957
Hotel Statler

REGION SEVEN
Portland, Oregon
May 2-5, 1957
Heathman Hotel

THE OHIO CHIROPODISTS ASSOCIATION
Scientific Convention
Columbus, Ohio, May 24-26, 1957
Deshler-Hilton Hotel

REGION TWELVE
Western Chiropody Conference
San Francisco, Cal.
May 30-June 1, 1957
Sheraton-Palace Hotel

REGION NINE
CHIROPODY ASSOCIATION OF FLORIDA
35th Annual Convention and
Scientific Conclave
Tampa, Fla., May 30-31, June 1, 1957
Floridan Hotel

SOUTHWESTERN CHIROPODY CONGRESS
Houston, Texas
June 13-15, 1957
Shamrock-Hilton Hotel

REGION ONE
Boston, Mass.
Sept. 13-15, 1957
Sheraton Plaza Hotel

REGION EIGHT
Huntington, W. Va.
October 4-6, 1957
Pritchard Hotel

MISSOURI ASSOCIATION OF CHIROPODISTS
Kansas City, Mo., October 11-13, 1957
President Hotel

REGION TEN
Montgomery, Ala.
Sept. 6-8, 1957
Whitley Hotel

NORTH CAROLINA CHIROPODISTS ASSOCIATION
Fayetteville, N. C., June 17-18, 1957
Prince Charles Hotel

ACCREDITED CHIROPODY COLLEGES

California College of Chiropody
1770 Eddy Street
San Francisco, Calif.

Chicago College of Chiropody
1422 W. Monroe Street
Chicago, Ill.

Illinois College of Chiropody and Foot Surgery
1327 North Clark Street
Chicago, Ill.

New York College of Podiatry
53 East 124th Street
New York, N. Y.

Ohio College of Chiropody
2057 Cornell Road
Cleveland, Ohio

Temple University, School of Chiropody
1810 Spring Garden Street
Philadelphia, Pa.

DEATHS REPORTED

Dr. Philip J. Emmons
Holyoke, Mass.

Dr. Philip J. Emmons, age 64, died suddenly of a heart attack Thursday, February 7th. Dr. Emmons practiced in Holyoke for the past 32 years. He was born in this city, attended the local schools and graduated from the Boston School of Chiropody in 1924.

In 1952 Dr. Emmons became a Fellow of the American Society of Chiropodical Roentgenology. In addition to membership in several chiropody associations, he belonged to the Holyoke Lodge of Elks and was an active member of the Cercle Rochambeau. Surviving him is his wife, the former Cora Goyette.

Charles E. Kemp, F.Ch.S.
London, England

Charles E. Kemp of London, England, passed away on November 25, 1956. Mr. Kemp succeeded Mr. A. J. R. Bride as Head of the Chelsea School of Chiropody in 1940. He served several years as Vice-President of the Society of Chiropodists. He was the author of a treatise, "Chiropody Instruments," published in 1951 by the Actinic Press.

Dr. Lily M. Hall
Bridgeton, N. J.

Dr. Lily M. Hall of Bridgeton, N. J., passed away on February 22, 1957. Dr. Hall was one of the oldest practitioners in Southern New Jersey. She is survived by her son, Dr. Wesley Lake Hall.

Dr. Nathan Berkowitz
New York, N. Y.

Dr. Edward C. Holloway
Newport, R. I.

Dr. Annie M. Halpin
Newport, R. I.

Dr. Hugo Windner
Brooklyn, N. Y.

Dr. H. E. Greenbaum
Youngstown, Ohio

COMFORTS
Cools, Relaxes
TIRED, BURNING, ITCHING FEET
ICE-MINT
MEDICATED FOOT CREAM
(contains lanolin)

When patients complain of tired burning feet as the heat soars, recommend soothing, cooling ICE-MINT. A white, clean, non-irritant cream containing the finest camphor gum, essential oils of peppermint, eucalyptus, thyme and camphor—in a special base containing soothing lanolin. Write for free samples.

UNITED SALES & MFG. CO.
Division of FOSTER-MILBURN CO.
468 Dewitt Street, Buffalo 13, N. Y.

The
ADLER
SURGICAL SUPPLY COMPANY
IS
"A Wonderful Place To Do Business"

Here's Why:

Only a graduate chiropodist can fully appreciate your further needs. A graduate chiropodist has the background to plan an efficient office, the office you deserve. Behind our Surgical Company lie 20 years of learning through professional experience, qualifying Sol ADLER, D.S.C., Temple '37, as an economic consultant in chiropody office planning. In this respect, all surgical supply houses are NOT alike.

Let our knowledge be your guide to future success!

554 North 17th Street
Philadelphia 30, Pennsylvania **RI 6-0942**

ADVERTISERS INDEX

Adler Surgical Supply Company A31
Archcraft Laboratories A27

Baltor Bracelet A34
Beaver Knives A23
Bergmann, Carl G., D.S.C. A25
Bristol-Myers Co. .....Outside Back Cover
Burroughs Wellcome & Co. A15
Butler's Chiropody Supply Co. A29

Campbell Pharmaceutical Co. A11
Chicago Medical Equipment Co. A27

Dallek, Dr. A. A33
Desitin Chemical Co. .....Inside Front Cover
Dome Chemicals, Inc. A18
Dome Chemicals, Inc. A19

Fay, Carl F., Estate A24
Fischer, R. A., & Co. A23
Footcare Products for Children A32
Foot Facts Publications A32
Foot-so-Port Shoe Co.
.....Facing Inside Front Cover
Foredom Electric Co. A24

Griswold Salve Co. (Sisson Drug Co., The) A33

Herbst Shoe Manufacturing Co.
.....Inside Back Cover
Hirsch Laboratories A8
Hoffman-LaRoche A13

Levy & Rappel, Inc. A22
Liquid Rubber Appliance Lab. A20
Liquid Rubber Appliance Laboratories .. A28

McDowell Manufacturing Co. A25
Monnon Company A16
Mowbray Company, The A34

N.A.C. Agency, Inc., The A21

Professional Printing Co., Inc. ...A29, A33, A34

Reece Wooden Sole Shoe Company A26
Region 6 ..... A14
Ritter Company A5

Stella, F. P., & Sons Products A22
S.S.S. Company A29

United Sales & Mfg. Co. A31
(Div. Foster-Milburn Co.)
U. S. Vitamin Corporation A3

Wallace & Tiernan, Inc. A7
(Maltbie Laboratories Div.)
Westwood Pharmaceuticals A1
(Div. Foster-Milburn Co.)
Winthrop Laboratories A9
Women's Auxiliary A17
Wooley, W., & Co. A34

50 Years!
Time to Educate our
Patients Better with

FOOT FACTS

Publications

P. O. BOX 985
MIAMI BEACH 39, FLORIDA

SUCCESSFUL FOOT SPECIALISTS ARE USING

TAX FOOT MOLD SHOES

For MEN and WOMEN
Designed for Simple Office Molding
Available in Open and Closed Models
Beautiful Sandals — Smart Oxfords
Available through Podiatrists-Chiropodists Only

FOOTCARE PRODUCTS for CHILDREN

N. Y. Office
Alfred H. Tax
43-47 44th St., L. I. City 4, N. Y.

St. Louis Office
Dr. Gerald Cohen
3150 So. Grand Blvd., St. Louis, Mo.

Virginia Office
Dr. Julian Levin
3147 No. Washington Blvd.,
Arlington, Va.

CLASSIFIED ADVERTISEMENTS

Advertisements not exceeding 30 words cost $3.00. Additional words 10 cents each.

Commercial classified advertisements—minimum 30 words $10.00; 30 cents per additional word.

All classified ads payable in advance. Remittance must accompany order for insertion.

Please do not ask for the names of classified advertisers in the JOURNAL who use box numbers. We accept such advertisements with the understanding that this information will not be released. Address replies or inquiries to the box number shown in the advertisement. They are promptly forwarded to the advertiser.

WANTED: June graduate from the Ohio College of Chiropody desires to purchase established practice in Cleveland. Write 404, c/o National Association of Chiropodists, 3301 16th Street, N.W., Washington 10, D. C.

FOR SALE: Texas practice in an excellent town, ideal climate—combination office and residence a really fine set-up. Write 406, c/o National Association of Chiropodists, 3301 16th Street, N.W., Washington 10, D. C.

DETROIT. Associate to acquire practice within six months after close of deal. Write 410, c/o National Association of Chiropodists, 3301 16th Street, N.W., Washington 10, D. C.

New York to California

Foot Specialists in each location use different designs in padding the human foot. It's an education to see what others use. You can save money and time in the use of our pads. Felt-Foam-Moleskin, any thickness. With or without adhesive. Descriptive booklet, prices and samples mailed free.

Professional Pads
Dr. A. Dallek
790 E. Tremont Ave.
N. Y. City, 60

GRISWOLD'S

FAMILY SALVE

Your insurance of a satisfied patient. The finest adhesive for felt.

Sold by all supply houses

The Griswold Salve Co.
Hartford, Conn.

CANADIAN chiropody practice (and equipment) for sale. Established 18 years, central Montreal, facing McGill campus. Redecorated 7-room apartment. Clientele *second to none.* Lifetime opportunity. April or May, before rush. Write Miss Jeanne Faubert, R.N. Ch., 900 Sherbrooke Street, W., Apt. 10, Montreal, P. Q., Canada.

FOR SALE: Rare opportunity to purchase an active and established practice of 32 years, in northern part of Indiana. Three fully equipped operating rooms, x-ray and dark room. Terms. Ill health. Write 408, c/o National Association of Chiropodists, 3301 16th Street, N.W., Washington 10, D. C.

FOR RESULTS TRY
CLASSIFIED ADS

in the

JOURNAL N.A.C.

They will help secure a new location, practice equipment, apparatus, books, instruments, a successor, partner, associate or assistant. The Journal has proved an excellent medium for any of the above purposes. The classified columns can be of genuine service to advertisers and members. Commercial and personal rates are shown at the head of the column. If you desire more specific information concerning classified advertising, write to:

Journal of the National
Association of Chiropodists
3301 16th St., N. W.,
Washington 10, D. C.

FOR SALE: Chiropody practice established 12 years in El Paso, Texas. Come see this offer. Fast-growing city over 200,000 with healthful climate. John H. Heiden, D.S.C., 418 Mills Building, El Paso, Texas.

FOR SALE: Well-established podiatry practice. $4.00 minimum. Upstate New York. Area booming! Drawing population over 50,000. Ritter electric operating chair. Must be seen to be appreciated. Other business interests. Write 402, c/o National Association of Chiropodists, 3301 16th Street, N.W., Washington 10, D. C.

OUR ADVERTISERS
ARE
YOUR FRIENDS

Skin Adherent
No. 2

Convenient
to use
Non-irritating
SEND FOR SAMPLE

THE MOWBRAY CO., WAVERLY, IOWA

LIQUID LATEX

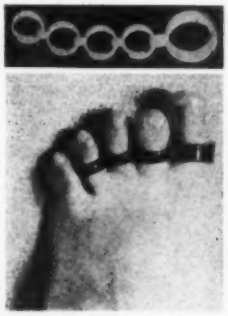
Extra thick. You can thin it yourself to suit your needs. White or Green Colors. Write for sample with prices.

W. WOOLEY & CO.
1016-CH Donald St., Peoria, Illinois

BARGAIN. Ritter X-Ray-Stat. Ortho-X-Poser, view box, hangers, holders, markers, dark room light. Guaranteed excellent condition. Creme color. Sale $600.00 cash. Drs. Wagaman and Bruce, 301 Green Street, Fayetteville, North Carolina.

DUE TO the death of Dr. Leo Sheldon, his established practice of thirty-two years is for sale. The offices in both Excelsior Springs, Missouri, and Kansas City, Missouri, are fully equipped. For information write Mrs. Leo Sheldon, 900 St. Louis, Excelsior Springs, Missouri.

WANTED TO BUY: California practice or any equipment that is in good condition. Send description and price to William O. Nankee, D.S.C., 259 North Euclid Avenue, Pasadena, California. Telephone SYcamore 6-8760.



BALTOR BRACELET
3800 Poplar Ave.
Brooklyn 24, N. Y.

Patent No. 2471097 was granted to the Baltor Bracelet as — DEVICES FOR STRAIGHTENING TOES.

It will exercise the toes by holding them in sideways left-right stretch, lost in shoes.

It provides a wider toe-spread, facilitating the circulation of healing fresh air.

IF Rehabilitation of your patient is your goal–

IF You want complete mechanical assistance–

IF You want expert consultation–

THEN—We want to work with you on all of your mechanical problems.

HERE IS THE WORK WE TAKE PRIDE IN DOING.

BALANCE INLAYS—All of our inlays employ the bi-plane principle and are made over your slipper casts. We adhere to your prescription for all corrections. You can vary your order from flexible to rigid inlays and with any accommodations–including **Levy Mold** type.

METAL INLAYS—All made to slipper casts. We will design regular Whitman plates, Robert's plates, simple Schaeffer plates, and special metal plates as desired.

BRACHMAN "SKATES"— These ambulatory double-bar skid plates attached to surgical shoes are acknowledged by chiropodists and orthopedic surgeons as the ideal treatment for gait problems associated with the various types of talipes, cerebral disturbances in children, and problems of intoeing and outoeing associated with limb rotation. Write for our free brochure describing its uses.

Shortage boots—Made to casts.

Amputation boots—Made to casts.

Ankle balancers—Made to casts.

SPECIAL— Write for Dr. Brachman's new approach to the clinical diagnosis and treatment of metatarsal problems. You will find it revolutionary and easy to use in your practice. Available free of charge.

WE INVITE YOU to join our growing list of customers–the outstanding group of chiropodists in America.

Brachman Laboratories, Inc.

3126-30 North Halsted Street

Chicago, Illinois

SET YOUR DATES **NOW** FOR ATTENDANCE

N. A. C.

45th Annual Convention

Thirty-Seventh Meeting

of the

HOUSE OF DELEGATES

August 16 and 17

DRAKE HOTEL - CHICAGO, ILL.

Some Themes of the 1957 Convention

A partial listing (more to follow) of the

SCIENTIFIC PROGRAM AUG. 18-19-20

AN AWARD WINNING PAPER EVERY DAY

1. GERIATRIC CHIROPODY
   Medical Aspects Onychiatry
   Institutional Care Office Care P.V.D., etc.
2. HEMATOLOGY as a KEY to TREATMENT in ANKLE EDEMA
3. TIGHTENING of LAX LIGAMENTS by SCLEROSIS
4. PROBLEM PLANTAR LESIONS
5. ALLERGY—SENSITIVITY—FUNGUS—or?
6. MEDICAL TREATMENT of FOOT CONDITIONS
   Pharmaceuticals Indications
   Typical Prescriptions Contra-indications
7. FOOT SURGERY
8. SYMPOSIUM on APPLIANCES, DEVICES, PROSTHESES:
   Metal, Plastic (Acrylic and other) Leather, Latex
9. X-RAY EVALUATION of BONE PATTERNS

Hall of Science—Continuous Science Theatre—Technical Exhibits

Specialty Society Meetings—Ladies' Program—Fun

Five Days of Completely Air-Conditioned Comfort

MAKE YOUR RESERVATION EARLY

THE NATIONAL ASSOCIATION OF CHIROPODISTS

Committee on Membership
To
All Chiropodists

The National Association of Chiropodists comprises fifty units—forty-nine affiliated state societies (made up of active, passive and transient individual members) and one service unit. The forty-nine state organizations possess a wide degree of autonomy. These units formulate the policies and control the budget of the N.A.C. through representation in the House of Delegates.

The service unit is made up of the officers and members of the Executive Council of N.A.C., N.A.C. Councils and Committees, and a headquarters staff supplemented by specialized personnel who render specific service as required. The service unit provides essential administrative functions and renders service to the forty-nine state units. This unit, particularly the headquarters office, is able to offer such services as are determined by the House of Delegates. It has only that authority delegated to it by the House of Delegates and the Executive Council.

When the forty-nine state societies desire to accomplish something on a national basis they pool their resources through the medium of the service unit which is the coordinating body of the N.A.C. All assignments, programs, etc., handled by the service unit are sponsored by the national organization and are conducted in fifty fields—forty-eight states and the District of Columbia and on a national scale through the service unit. Practically everything on the agenda of the N.A.C. is designed to achieve proper status for the entire profession and its individual practitioners.

It can be *your* privilege to become a part of this force.

What the N.A.C. Offers Its Members

1. Members receive the JOURNAL of the N.A.C. monthly containing scientific articles, editorials, current information, committee reports, state news and other regular features. As a member you can become one of the select group contributing to its pages.
2. The N.A.C. is the largest and strongest group fighting for our profession.
3. Dues are fixed at a nominal sum which include a subscription to the JOURNAL.
4. The N.A.C. is made up of the various state societies.
5. An effective information service which is available to all members is centered in the headquarters.
6. Membership cards and other identification material are supplied to each member.
7. A complete program of insurance including professional and premises liability, health and accident, life, extended coverage, and major medical is offered our members at substantial savings.

MEMBERSHIP IS A PRIVILEGE

MEMBERSHIP IS A PRIVILEGE

8. Through the efforts of the N.A.C. a large and increasing number of health and accident insurance companies and prepaid health plans recognize the claims of patients for services performed by chiropodists.

9. Consultation and assistance is available in the preparation of printed material for professional purposes.

10. A Legislative Committee keeps informed and is available to help the various state societies in their activities with state legislatures.

11. A Committee on Publications keeps the profession informed on all our periodicals.

12. Constant contact with the medical, dental, pharmaceutical and other professions provides a basis for interprofessional cooperation.

13. The Council on Education provides information on the status of chiropody-podiatry teaching institutions and accredits them for listing by the Office of Education, Department of Health, Education and Welfare.

14. The Vocational Guidance Committee conducts an intensive program in vocational guidance and student recruitments for our schools.

15. The Audio-Visual Committee provides material for scientific and public education purposes for the members of the N.A.C.

16. The Membership Committee maintains an active program for securing new members.

17. Attendance at the N.A.C. Convention and at Regional Meetings provides members with the opportunity to keep abreast with current knowledge, advanced techniques and old friends.

18. The Federal and Military Affairs Committees and the N.A.C. headquarters office conduct extensive programs in Washington, D. C. to inform and educate public and private agencies and officials.

19. Problems concerning research, ethics, economics, etc. are constantly studied by various committees of the N.A.C., and the information thus obtained is made available to the membership.

20. Headquarters keeps constantly informed of the activities of all affiliated and non-affiliated chiropody organizations.

This list might well include a hundred other detailed advantages of membership. The N.A.C. offers, above all, the great feeling of satisfaction that comes from belonging and participating in a growing, forceful organization which devotes its entire program to the betterment of everyone.

The American Foot Health Foundation

In 1948 the N.A.C. sponsored the creation of the American Foot Health Foundation which has been organized for the purpose of conducting various programs directed specifically to the general public. This Foundation will sponsor research projects, public education programs and raise funds for its operation.

MEMBERSHIP IS A PRIVILEGE

MEMBERSHIP IS A PRIVILEGE

Objectives

Among the future objectives toward which the members of the N.A.C. strive are those concerned with the improvement of education—the education of our members and the education of the public. We wish to establish a library and permanent source of information relating to foot health in all its aspects. We desire more participation in school health services, hospitals and institutions, Federal service, state and local public health departments, prepaid health plans, and workmen's compensation acts.

Other objectives are concerned with the creation of consultation service for footgear, pharmaceutical and allied associations and industries. To expand our research program in scientific, social and economic fields is another outstanding goal of the N.A.C.

To help achieve these objectives the following is our

Current Program

ACTIVATION of the Regional Plan as a means of gaining increased membership, better representation, and a stronger N.A.C. organization.

CONTINUED improvement of the caliber of the N.A.C. JOURNAL, and increased income from advertising.

PUBLICATION of an N.A.C. Directory this year with substantial income from advertising.

TRAINING of chiropodists for placement in industrial chiropody positions. This serves not only the individual chiropodist, but acts as a broad public relations endeavor.

CAMPAIGNING vigorously to gain authority for chiropody under all insurance policies related to disabilities within our scope.

SUPPORT of our educational institutions by assisting in student recruitment; liaison between our institutions and Federal agencies to improve the status of the profession; expanded research assignments to our colleges.

ACQUIRING statistical information of our profession through economic surveys.

ASSISTANCE to the individual chiropodist to aid him in improving his practice potential.

IMPLEMENTATION of a comprehensive program of medical relations.

ACTION in all areas of the Federal Affairs prospectus.

INTENSIFICATION of effort in public information and public relations.

Recent Accomplishments

1. Improved format and contents of the JOURNAL.
2. The commissioning of chiropodists as chiropodists in the Medical Service Corps of the Army, culmination of years of effort.
3. A working vocational guidance program.
4. Establishment of good liaison with the Department of Health, Education and Welfare, particularly the Office of Education and the United States Public Health Service.

MEMBERSHIP IS A PRIVILEGE

NEW ☐ ACTIVE ☐ ASSOCIATE ☐ REINSTATEMENT ☐ AFFILIATE ☐ CONDITIONAL ☐

State Secretary — Check Classification of Applicant

APPLICATION FOR MEMBERSHIP

PLEASE PRINT INFORMATION ON THIS FORM

NATIONAL ASSOCIATION OF CHIROPODISTS AND AFFILIATED STATE SOCIETIES

I hereby make application for membership in the

.....
(Name of State Organization)

and if elected I agree to uphold its purposes, constitution and by-laws together with those of the National Association of Chiropodists. I further agree to abide by the code of ethics and all rules and regulations prescribed by the House of Delegates, Executive Council of the National Association of Chiropodists.

If I am accepted as a member it is with the understanding that membership emblems and annual certificates are and will remain the property of said state society and the National Association of Chiropodists respectively and are only held in trust, and I agree to return them to the Secretary of the state society if I, for any cause, cease to be in good standing as a member.

Date ..... 19.....

Name .....
(Name in full including middle name)

.....
(No. and St.) Office Address (City and State)

.....
(No. and St.) Residence (City and State)

Place of Birth.....

Professional Education Obtained.....Year of Graduation .....
(Name of College)

Other College or University Education.....Degrees .....
(Name of Institution) years year

.....

.....

States Licensed in .....

Dates Licenses Issued.....

How long engaged in practice.....

Have you previously applied for membership in the National Association of Chiropodists?.....

.....
(State when and where)

Has your application ever been rejected? .....

Do you practice Chiropody exclusively? .....Please attach letterhead and professional card.

Recommended by .....

Applicant's Signature .....

Recommended by .....

.....

THIS SPACE FOR STATE SOCIETY RECORDS

Date Application Received.....

Date Elected to Membership.....

Dues Received with Application ..... Remarks .....

CODE OF ETHICS

National Association of Chiropodists and Affiliated State Societies

1. The conduct of a practitioner of Chiropody (Podiatry) shall, at all times, be such as becomes a gentleman, and should be creditable to the profession of which he is a member. He shall be temperate in all things, for the practice of Chiropody (Podiatry) requires the unremitting exercise of a clean and vigorous understanding, a steady hand and an accurate eye. These are essential to the welfare and even the life of a human being.

2. A Chiropodist (Podiatrist) should always recognize poverty as presenting valid claims for gratuitous service, but endowed institutions, societies for mutual benefit, life insurance companies or analogous organizations are not entitled to receive such services.

3. A Chiropodist (Podiatrist) shall not give or offer, or shall he undertake or promise to give either directly or indirectly, any gift, gratuity, commission or bonus in consideration of or in return for any patient for chiropodical treatment, or in consideration of or in return for the referring, recommending, or procuring of any patient or patients for treatment. A Chiropodist (Podiatrist) shall not request, solicit, accept or receive any such gift, gratuity, commission or bonus.

4. A Chiropodist (Podiatrist) shall not request, solicit, accept or receive any rebates or commissions from the prescribing of any drug, medicine or other agent used therapeutically. It is unethical for a chiropodist (podiatrist) to enter into contracts or agreements which impose conditions that make it impossible to deal fairly with the public and fellow practitioners in the locality. Contracts that convey exclusive rights or restrict the practitioner from divulging certain information shall be considered unfair.

5. The confidence and knowledge which Chiropodists (Podiatrists) receive, through their professional attendance upon patients, should be guarded with the most scrupulous care.

6. He shall not, at any time, criticize a fellow practitioner or his work, in the presence of a patient.

7. He must always be willing to assist a fellow practitioner by word or deed, when called upon to do so, provided, however, that it does not legally or financially embarrass him.

8. In consultation, there shall be no insincerity, rivalry or envy. He shall show proper respect for the Chiropodist (Podiatrist) in charge of the case.

9. Whenever a Chiropodist (Podiatrist) requests another Chiropodist (Podiatrist) to attend his patients during his temporary absence from his practice, professional courtesy requires the acceptance of such appointment if consistent with other duties. The Chiropodist (Podiatrist) acting under such appointment should give the utmost consideration to the interests and reputation of the absent Chiropodist (Podiatrist). All patients, both old and new, shall be restored to the care of the latter upon his return.

10. He shall not try to induce a patient of a fellow practitioner to become his patient, either by belittling his colleague's work or by the promise of better care or a lower fee.

11. If a fellow practitioner applies for treatment for himself, such treatment shall be given without compensation, except when an actual outlay of money is involved; then compensation for the actual expense can be expected.

12. Everyone entering the profession, and thereby becoming entitled to full professional fellowship, incurs an obligation to observe strictly such laws as are instituted for the government of the members of the profession; to honor the fraternity as a body; to exalt its standing and to extend all the bounds of its usefulness.

13. Every Chiropodist (Podiatrist) should guard and protect the chiropody profession against those who are ethically unfit as professional associates. A member of this Association should expose, before the proper tribunal, corrupt or dishonest conduct of members of the chiropody profession.

14. Objectionable advertising in any manner is detrimental to the dignity of the profession, and therefore cannot be tolerated. All listing in directories of any sort, shall be uniform as to type, size and color.

a. It shall be unethical to advertise directly or indirectly by radio, newspapers, telephone directory, or any periodical. All listings in directories shall be uniform. Bold face type shall not be used in any listings or printed announcements. No prices for professional services shall be announced in any printed matter or signs. No practitioner may have any part of his listing printed in any manner that will make such listing distinct from that of his fellow practitioner and under any other listing than "Chiropodists" or "Podiatrists."

b. It shall not be considered unethical to display a dignified sign at the entrance to an office, or on the window, containing not more than the name, degree and the designation Chiropodist (Podiatrist). The use of illuminated signs shall be construed as objectionable advertising. The practice of Chiropody-Podiatry in a barber shop, beauty parlor, shoe store or department store, or any other similar commercial establishment, or having an entrance through or to such establishment is not in keeping with the general ethical and professional standards of the Chiropody profession.

c. Dignified professional cards containing the name, title, degree, office location, office hours, phone number (and residence address and phone number, if desired) may be used. Such cards may not exceed the dimensions of 3½ by 2 inches. Newspaper announcements may be run only for the announcing of the opening of an office, change of address, absence from or return to practice. Announcements may not be larger than seven square inches, must not run more than three consecutive times and must be strictly limited to the information permitted on a professional card.

d. A Chiropodist (Podiatrist) shall not make use of or knowingly aid or permit others to make use of him as a subject of any manner or form of publicity through lay channels, either alone or in connection with others, which shall be of such character as to invite attention to him or to his professional position, skill, qualifications, achievements, attainments, associations, affiliations or honors and/or of such character as would ordinarily and reasonably result in his aggrandizement. A Chiropodist (Podiatrist) shall not boast of his cases, operations, cures or remedies or knowingly permit or aid or encourage the publication of reports thereof through lay channels.

e. The Association recognizes the obligation of the chiropody profession to give to the public information necessary and desirable for the promotion and preservation of foot health and also recognizes that addresses before lay audiences, radio broadcasts, and articles in lay publications are valuable and proper methods of health education. A Chiropodist (Podiatrist) shall not be considered guilty of unprofessional conduct within the meaning of this section, who allows his name to be announced in connection with such addresses, broadcasts, or printed articles, together with announcement of such positions or appointments held as are generally recognized as carrying "weight of authority." The content of his address or printed articles must be of general educational import and must not, either directly or by implication, refer to the accomplishments, experience or ability of himself or of any clinic, school or hospital with which he is connected, in such manner as would ordinarily and reasonably result in self aggrandizement.

f. A Chiropodist (Podiatrist) proposing to address a lay group, either directly or by radio, if time permits, shall first secure from the Executive Council of the component Chiropody Association of the county in which the address is to be given, permission for its delivery and approval of its content.

g. In such public education the dictates of good taste should be observed. To announce or allow to be announced, in such connection, a Chiropodist's (Podiatrist's) address or telephone number, shall be regarded as unprofessional conduct. Announcement of an unnecessary number of titles, or positions or appointments held should be avoided. The conduct of a regularly appearing broadcast or signed column by the Chiropodist (Podiatrist) in active practice shall be regarded as unprofessional conduct within the intent of this section, except when such regularly appearing broadcast or column is specifically authorized by the Executive Council of the Chiropodist's component Chiropody Association. Scrupulous care should be taken that statements made to the public are accurate and correct in accordance with current knowledge and opinion of the Chiropody profession rather than personal opinion of the individual Chiropodist (Podiatrist).

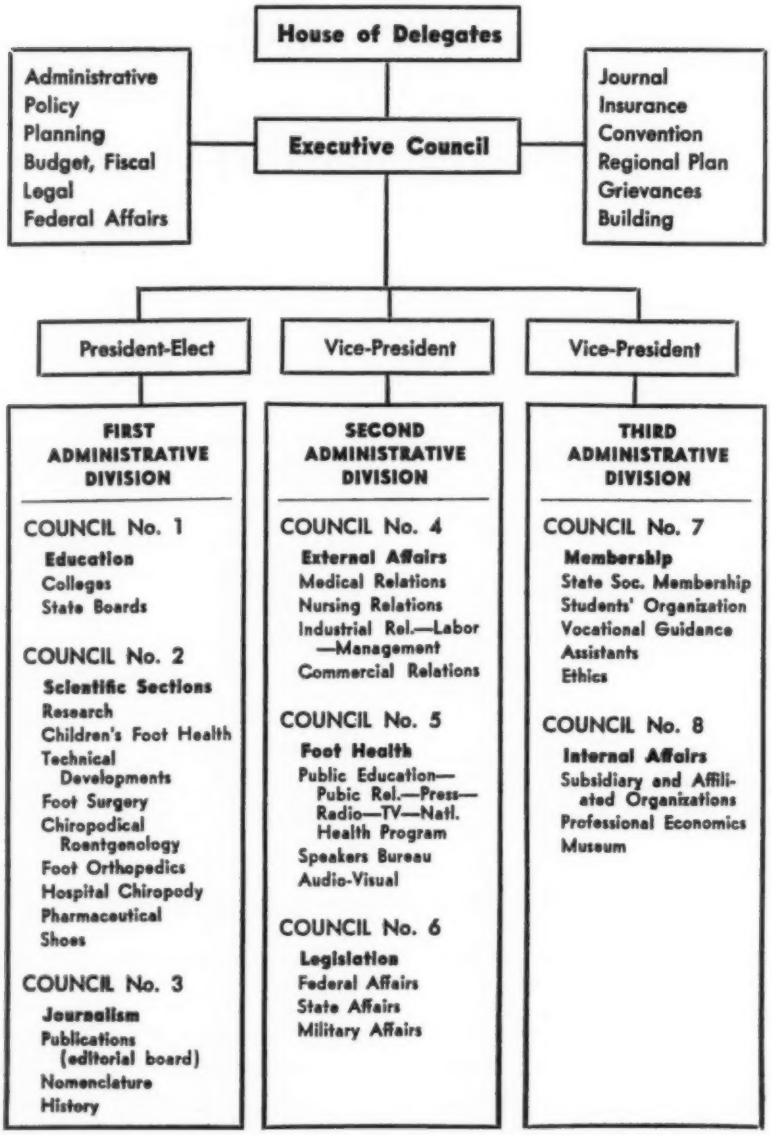
15. Every Chiropodist (Podiatrist) should identify himself with the organized body of his profession in the community in which he lives. Such societies, constituting as they do, the chief element of strength in the organization of the profession, should have the active support of their members and should strive for the cultivation of fellowship, the exchange of professional experience for its advancement, the maintenance of ethical standards and for the promotion in general of the profession and the welfare of the public.

16. All local societies thus organized, should affiliate themselves with the State and National organizations.

17. It adds dignity to the profession of Chiropody (Podiatry) when the ethical conduct of its members is in keeping with that of other professions of high ethical standards. Therefore, every Chiropodist (Podiatrist) should strive to gain the respect of other legalized professions, by word and deed, for in so doing, the profession of Chiropody (Podiatry) will be elevated among the professions of high standards.

18. These principles of professional conduct shall apply to Chiropodists (Podiatrists) as individuals, or as members of the Chiropody department of hospitals, dispensaries, clinics, laboratories, schools, foundations or any other groups, by whatsoever name they may be known.

ORGANIZATION CHART
NATIONAL ASSOCIATION OF CHIROPODISTS



Child Life
SHOES

adaptable
n any of these directions.

It is always easier to insert wedges into shoes that have been made with this purpose in mind, than to attempt to wedge conventional shoes. It is less difficult for the shoemaker, more resultful for the doctor, and less expensive for the patient.

CHILD LIFE Arch Feature shoes are especially made to be readily adaptable for the wedge inserts required for the correction of four of the most common types of foot deficiencies in children. Yet these prescription type shoes are styled so that their appearance is identical with that of conventional shoes. There can be no feeling of inferiority on the part of young patients who wear them.

Nine chances out of ten there is a specially selected CHILD LIFE dealer in your community who will be glad to accept your prescription work and who is competent to handle your instructions. Write for his name, and for the CHILD LIFE service booklet for the professional man, featuring representative shoes and wedging procedures.

Child Life
SHOES

on exhibit
Chiropody Science Conclave
Region No. 3
April 25-28
Atlantic City
BOOTH No. 15

HERBST Shoe Manufacturing Co.

Milwaukee 45, Wisconsin

When the problem is rheumatic or arthritic pain, MINIT-RUB® brings comfortable relaxation the easy, greaseless way. This counterirritant heat is an excellent adjunct to systemic arthritic therapy.

The week-end enthusiast who sporadically overworks his muscles needs help *fast*. MINIT-RUB brings deep, warming relief.

For colds, MINIT-RUB applied to the chest relieves soreness and congestion; inhaled it reduces stuffiness.

On "footsore" days, a little MINIT-RUB briskly applied to insteps and arches is bracing to tired feet.

Bristol-Myers Co., 19 West 50 Street, N. Y. 20, N. Y.